MEDI-CAL ASSUMPTIONS
MAY 2006
FISCAL YEARS 2005-06 & 2006-07

INTRODUCTION

The Medi-Cal Estimate, which is based upon the Assumptions outlined below, can be segregated into two main components: (1) the base, and (2) the adjustments to the base. The base estimate is the anticipated level of program expenditures assuming that there will be no changes in program direction, and is derived from a 36-month historical trend analysis of actual expenditure patterns. The adjustments to the base are the estimated fiscal impacts of any program changes which are either anticipated to occur at some point in the future, or have occurred so recently that they are not yet fully reflected in the historical data base. The combination of these two estimate components produces the final Medi-Cal Estimate.
Note: A list of acronyms and abbreviations has been provided following the Assumptions Section.

BASE ESTIMATES

The base expenditure projections for the Medi-Cal estimate are developed using regression equations based upon the most recent 36 months of actual data. Independent regressions are run on user, claims/user or units/user and $/claim or $/unit for each of 18 aid categories within 12 different service categories. The general functional form of the regression equations is as follows:

	USERS	=	f(TND, S.DUM, O.DUM, Eligibles)
	CLAIMS/USER	=	f(TND, S.DUM, O.DUM)
	$/CLAIM	=	f(TND, S.DUM, O.DUM)
WHERE:	USERS	=	Monthly Unduplicated users by service and aid category.
	CLAIMS/USER	=	Total monthly claims or units divided by total monthly unduplicated users by service and aid category.
	$/CLAIM	=	Total monthly $ divided by total monthly claims or units by service and aid category.
	TND	=	Linear trend variable.
	S.DUM	=	Seasonally adjusting dummy variable.
	O.DUM	=	Other dummy variables (as appropriate) to reflect exogenous shifts in the expenditure function (e.g. rate increases, price indices, etc.).
	Eligibles	=	Actual and projected monthly eligibles for each respective aid category incorporating various lags based upon lag tables for aid category within the service category.

Following the estimation of coefficients for these variables during the base period, the independent variables are extended into the projection period and multiplied by the appropriate coefficients. The monthly values for users, claims/user and $/claim are then multiplied together to arrive at the monthly dollar estimates and summed to annual totals by service and aid category.

ELIGIBILITY: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 0.1 (PC-143)		X	Hurricane Katrina Section 1115 Demonstration Waiver

The federal government has approved California's participation in the Hurricane Katrina Section 1115 Demonstration Waiver. Under this waiver, an evacuee may apply for coverage between August 28, 2005 and January 31, 2006. Coverage continues for five months from month of application. The final date of coverage is May 31, 2006, unless that date is extended by Congress. There are over 300 Medi-Cal evacuees and 2,500 CalWORKs evacuees that have Medi-Cal linkage that are eligible under the waiver. The total costs of the Medi-Cal services provided to these evacuees will be paid for by the home state of the evacuee, resulting in 100 percent coverage of those Medi-Cal costs.

E 0.2 (PC-142) X Eligibility for Children in Month Prior to SSI/SSP Grant

Currently automatic eligibility for Medi-Cal is provided to Supplemental Security Income/State Supplementary Payment (SSI/SSP) program recipients in the month in which they receive their first SSI/SSP check. This is the month following the month of application for SSI/SSP, or the month in which their SSI/SSP eligibility is determined, whichever is later. This eligibility is established systematically on the Medi-Cal Eligibility Data System (MEDS) based upon information that comes from the Social Security Administration through monthly transmission of computer files.

The Deficit Reduction Act (DRA) of 2005 creates a mandatory program for disabled individuals under 21 years of age who are determined to be eligible for SSI/SSP and receive their first check in the following month. The DRA provides these individuals with Medicaid in the month prior to the first month in which they receive a grant. CMS has given the Department its approval to establish this eligibility systematically based upon the dates included in the monthly computer data files received from SSA. This mandatory coverage group will be effective with the February 2007 month of eligibility.

"PC" refers to "Policy Change".
"PC-1" means the fiscal impact of this assumption is in Policy Change 1.
"PC-BA" indicates the fiscal impact is a base adjustment or other part of the base.
"PC-CA" means there is a fiscal impact on County Administration.
"PC-OA" means there is a fiscal impact on Other Administration.
"PC-NA" means there is no fiscal impact or that the fiscal impact is unknown.

ELIGIBILITY: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 0.3 (PC-148) (PC-CA)		X	Medi-Cal/Healthy Families Bridge Performance Standards To ensure that all children who are discontinued from Medi-Cal due to increased income have the opportunity to apply for the Healthy Families Program, the Department will implement county performance standards for compliance with the Medi-Cal-to-Healthy Families Bridge program, effective October 2006. Implementation of the standards is expected to increase the number of children eligible under the bridge program.
E 0.4 (PC-149)	X	X	Shift of CCS State/County Costs to Medi-Cal With implementation of the enhancements to the CMS Net system to utilize eligibility data stored on the MEDS, claims for California Children's Services (CCS)-Only children determined to be retroactively eligible for Medi-Cal may be processed in the claim payment system as CCS-Only prior to the Medi-Cal determination becoming effective in MEDS. In order to properly charge these costs to the Medi-Cal program, beginning in April 2006 these claims are being periodically reprocessed at the Medi-Cal Fiscal Intermediary. The reprocessing results in crediting the CCS Program for claims previously paid as CCS-Only and charging the costs to Medi-Cal. This reprocessing to capture retroactive Medi-Cal coverage will be an ongoing process and will occur every year.
E 0.5 (PC-OA)	X	X	Health-e App Health-e App is an electronic, web-based alternative to the traditional paper Medi-Cal/Healthy Families joint application, intended to reduce application processing time so that children can obtain needed health insurance as quickly as possible. Health-e App is available to enrollment entities in all California counties. MAXIMUS, the administrative vendor for the Managed Risk Medical Insurance Board (MRMIB), plans to make system changes to enable the general public to also use the Health-e App. The cost for system changes will be a one-time development cost in the current and budget years. CDHS will pay the federal Title XIX share of this cost via an interagency agreement with MRMIB.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 1 (PC-OA)	X	X	Single Point of Entry

The Department and the Managed Risk Medical Insurance Board (MRMIB) have developed a revised family application form that can be used for both the Healthy Families Program (HFP) and Medi-Cal. This form is sent to a Single Point of Entry (SPE), where it will be screened to determine whether it should be forwarded to a county welfare department (CWD) for a Medi-Cal determination or to MRMIB for a Healthy Families determination.

As part of the Governor's FY 2005-06 initiative to expand health insurance coverage for children, the Department is updating the joint Healthy Families/Medi-Cal application to further reduce the barriers to families applying for HFP and Medi-Cal. To accommodate these changes, the SPE will require systems modifications to accept the revised application and the determination of funding at MRMIB. These changes to the joint application will also result in changes to the electronic application (Health-e App). The additional cost for systems enhancements for the joint application revision will be a one-time development cost in the current year and the budget year. The Department will pay the federal Title XIX share of this cost via an interagency agreement with MRMIB.

E 2 (PC-4)	X	X	Bridge to HFP

The one-month Bridge from Medi-Cal to Healthy Families is currently for children who become ineligible for full-scope, zero share-of-cost (SOC) Medi-Cal. To be eligible for this Bridge, a child must have income between 100% and 200% of poverty (although the use of an income disregard effectively raises the upper limit to 250% of poverty). Title XXI federal funding is used for this additional coverage. Medi-Cal managed care plan members remain enrolled in the managed care plan during the months of additional eligibility. Plans receive an additional computation payment for each of these member months. **Effective 60 days after the joint Healthy Families and Medi-Cal application and the annual redetermination form are revised to include a consent to forward the information to the Healthy Families Program, CWDs will be required to monitor and report their compliance with the newly established Bridging performance standards. It is anticipated the CWDs' first Bridging report will be due on July 1, 2007. If the CWDs do not meet the performance standards, the Department may reduce the county allocation of funds by up to 2% in the following year.**

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 3 (PC-8)	X	X	Resource Disregard – % Program Children

Based on the provisions of Senate Bill (SB) 903 (Chapter 624, Statutes of 1997), resources will not be counted in determining the Medi-Cal eligibility of children with income within the various Percentage Program limits. Enhanced federal funding is available through State Children's Health Insurance Program (SCHIP).

E 4 (PC-10) X X New Qualified Aliens

The Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 (PRWORA), as amended by the Welfare Reform Bill, specifies that federal funding is not available for full-scope Medi-Cal services for most Qualified Nonexempt Aliens who enter the country on or after August 22, 1996, for the first five years they are in the country. Federal financial participation (FFP) is not available for nonemergency services for Not Qualified Aliens. These aliens are eligible for FFP for emergency services only. California is continuing to provide full-scope Medi-Cal services to aliens who have satisfactory immigration status under the pre-Welfare Reform laws. The cost of nonemergency services provided to the New Qualified Aliens is being identified through a retroactive tracking system and the federal government is being reimbursed on a retroactive basis for the FFP paid that is not available for these services.

Welfare Reform requires deeming an alien's sponsor's income and resources for Medicaid. Once a New Qualified Alien has been in the country for five years and the federal sponsored alien rules are applied, FFP is available for all services. The Centers for Medicare and Medicaid Services (CMS) has not issued instructions on how the sponsored alien rules are to be implemented by the states. The Department will continue to claim FFP for nonemergency services for persons who have been here for more than five years until those instructions are issued.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 5 (PC-9)	X	X	Refugees

Under the federal Refugee Act of 1980, the federal government will reimburse the State for 100 percent of the State's portion of the cost of Medi-Cal services for a limited period. For refugees in aid codes 01, 02 and 08, this federal funding is available during the first 8 months after admission effective December 1991. Effective June 20, 2000, Refugee Medical Assistance (RMA) provides 8 months of coverage even if Refugee Cash Assistance is discontinued or terminated. Asylees now receive 8 months of RMA from the date asylum is granted. Under the Trafficking Victims Protection Act of 2000, an individual who has been certified as a victim of a severe form of trafficking is considered a refugee and may receive refugee benefits. Certain immediate family members of victims of a severe form of trafficking will also be eligible for refugee benefits under the Trafficking Victims Protection Act of 2003.

In 2004, the Department began monitoring RMA/Entrant Medical Assistance (EMA) cases, beginning with the four counties with the highest number of cases. This will be done annually. An ACWDL will be going to all counties with instructions on eligibility criteria for redetermination of RMA/EMA cases and instructions for referral of refugee children to the HFP.

E 6 (PC-OA)	X	X	SSA Costs for Health Coverage Information

The Social Security Administration (SSA) obtains information about health coverage and assignment of rights to medical coverage for Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipients. The Department uses this information to defer medical costs to other payers. SSA bills the Department quarterly for these activities.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 7 (PC-OA)	X	X	Postage & Printing

Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item as these costs are caseload driven. Postage and printing costs may be charged to local assistance if the postage and printing is for items that will be sent to or used by Medi-Cal beneficiaries.

Postage and printing costs for *Conlan, Schwarzmer, Stevens v. Bontá* lawsuit notices are included in this item.

Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal, Breast and Cervical Cancer Treatment Program (BCCTP) and Family PACT enrollees, and at least every 3 years to existing beneficiaries. Postage and printing costs for the HIPAA NPP are included in this item.

Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP are included as a 100% General Fund cost.

E 8 (PC-CA)	X	X	Systematic Alien Verification for Entitlement System

The federally mandated Systematic Alien Verification for Entitlement (SAVE) system was implemented in California on October 1, 1988. This system allows State and local agencies to make inquiries from a federal database to obtain information on the immigration status of aliens applying for entitlement benefits. The Department conducted an evaluation of the various modes available to access SAVE, and chose the existing IEVS system to provide that access. County administrative costs for using the SAVE system for Medi-Cal eligibility purposes are reimbursed 100% by the federal government.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 9 (PC-OA)	X	X	Maternal and Child Health

Federal matching funds are available for county administrative costs relating to the following services for Medi-Cal eligible women: (1) reduction of high death rate for African-American infants; (2) case management and follow-up services for improving access to early obstetrical care for pregnant women; (3) recruitment and technical assistance for providers under the Comprehensive Perinatal Services Program; (4) general maternal and child health scope of work local program activities, including perinatal education, services and referral; and (5) case management for pregnant teens, education and prevention of subsequent pregnancies.

E 10 (PC-OA) X X Outreach – Children

As a result of the Budget Act of 1997 and AB 1572 (Chapter 625, Statutes of 1997), the Healthy Families and Medi-Cal education and outreach campaign was launched in May 1998. The campaign included media, public relations, collateral, certified application assistants and training, a toll-free line for interested persons to call to request information and obtain an application, and contracts with community-based organizations and schools to provide outreach to enroll eligible children.

The Budget Act of 2002 eliminated the advertising budget, including general market and ethnic advertising, parental expansion advertising, and immigrant community advertising; public relations; and collateral. The budget also eliminated the community-based and school outreach contracts. The 2002-03 Mid-Year Reduction eliminated funding for training of application assistants. The 2002-03 outreach was limited to funding of application assistance fees and a reduced toll-free line. In the Budget Act of 2003 outreach funding is limited to funding of a toll-free line.

An Interagency Agreement with MRMIB was executed to fund the toll-free line with MAXIMUS starting January 1, 2004.

The Budget Act of 2005 included funding for the reinstatement of application assistance fees. The Interagency Agreement with MRMIB was amended to include the federal funding for Medi-Cal costs for application assistance fees for children placed on accelerated enrollment and for the Medi-Cal related costs of processing the application assistance payments. The General Fund is budgeted by MRMIB.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 11 (PC-CA)	X	X	Statewide Automated Welfare System (SAWS)

The Statewide Automated Welfare Systems (SAWS) consist of four county consortium systems: the Los Angeles Eligibility Automated Determination Evaluation and Reporting (LEADER), the Consortium-IV (C-IV), the CalWORKs Information Network (CalWIN), and the Interim Statewide Automated Welfare Systems (ISAWS). The four consortium systems may be reduced to three by 2009 when the counties who currently use ISAWS (in operation since 1998), complete their planned migration to C-IV.

The LEADER Consortium has been in the maintenance and operation stage since May 1, 2001. Los Angeles County successfully completed the automation of the Section 1931 (b) program, the Continuous Eligibility for Children (CEC) program, and the Medi-Cal application in the LEADER system in June 2004. The initial vendor contract for LEADER expired in April 2005. However, the County executed a 24-month extension to its base contract commencing May 2005 and ending April 2007. As a result of a county study and discussions with the State, the County intends to replace the LEADER system with another existing SAWS system. The County anticipates awarding a contract to a development vendor by April 2007. While the proposed replacement system is modified and implemented, the County projects that the existing LEADER maintenance and operations contract will have to be extended for an additional three years, through April 2010.

The CalWIN consortium is in the county conversion and system implementation stage. The first county underwent case conversion and system implementation on the CalWIN system in January 2005. As of ~~August 2005~~ **January 2006**, these counties have implemented CalWIN: Placer, Sacramento, Yolo, Santa Cruz, Santa Clara, Solano, ~~and~~ Contra Costa**, Sonoma, San Mateo, San Francisco, Alameda, and Tulare**. The remaining ~~11~~ **6** counties will be brought up on CalWIN, approximately one month apart, with final implementation ending in July 2006.

The C-IV consortium is currently in the maintenance and operation phase.

The ISAWS consortium is currently in the maintenance and operation phase. In December 2004, the ISAWS counties made the decision to migrate to the C-IV system. The ISAWS counties' Consortium Migration Project (ICMP) is currently in the planning stage.

In 1996, the Health and Human Services Data Center (HHSDC) was designated the lead State agency and project manager over the four county consortia systems. SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System (MEDS) interfaces.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
			The Department and the California Department of Social Services (CDSS), which fund the four consortia, approved a cost allocation agreement based on person counts, rather than case counts.
E 12 (PC-CA)	X	X	CalWORKs Applications The Budget Act of 1998 assumed that a portion of the costs for CalWORKs applications can be charged to Medi-Cal. CDSS has amended the claim forms and time study documents completed by the counties to allow CalWORKs application costs that are also necessary for Medi-Cal eligibility to be shared between the two programs.
E 13 (PC-OA)	X	X	State Hospital Eligibility Activities The Medi-Cal Program is funding administrative activities at Napa State Hospital and Metropolitan State Hospital related to ensuring that patients in the hospital receive any assistance necessary to gather data needed for the determination of Medi-Cal eligibility, and that Medi-Cal requirements are complied with.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 14 (PC-3) (PC-CA, FI)	X	X	CHDP Gateway

In order to help ensure that all children have access to medical care, the CHDP Gateway program was implemented July 1, 2003. Through this program, ~~over~~ **approximately** ~~700,000~~ **669,000** children receiving a CHDP screen in ~~2004~~ **2005** were preenrolled in Medi-Cal/Healthy Families for up to two months of full-scope benefits, during which time the family could choose to apply for continuing Medi-Cal/Healthy Families coverage. **Additionally, approximately 61,000 infants were deemed eligible for Medi-Cal/Healthy Families through the CHDP Gateway in 2005 for up to one year of full-scope benefits without applying. The total number preenrolled or deemed in 2005 was 730,000.** To facilitate this application, each child for whom the family indicates a desire for continuing Medi-Cal/Healthy Families coverage is sent a joint Medi-Cal/Healthy Families application and cover letter insert. The application contains a toll-free telephone number available to families who have questions about the program, and is printed in eleven languages. The application is returned to the SPE for Medi-Cal/Healthy Families.

The state-funded CHDP Program continues to provide screens to children eligible for limited-scope Medi-Cal. Effective October 1, 2003, the federal share of funding for the pre-enrollment costs is Title XXI funds, as required by federal statute. Sharing ratios are 65% FFP/35% GF for children with income between Medi-Cal limits and 250% of poverty. For children with income below Medi-Cal limits, the sharing ratio is 50% FFP/50% GF.

Medi-Cal receives funding from the Childhood Lead Poisoning Prevention (CLPP) Fund to cover blood lead testing as part of the CHDP Health Assessment for young children with risk factors for lead poisoning.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 15 (PC-CA)	X	X	*Craig v Bontá* Lawsuit

SB 87 (Chapter 1088, Statutes of 2000) added section 14005.37 to the Welfare & Institutions (W&I) Code. This section mandates that whenever a CWD receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits, the county shall promptly redetermine eligibility. The ex parte procedures for redetermining Medi-Cal eligibility described in this section are to be applied to all Medi-Cal beneficiaries discontinued from cash grant programs. The Department implemented the SB 87 procedures on July 1, 2001; however, the same SB 87 procedures were not applied to SSI/SSP Medi-Cal beneficiaries discontinued from SSI/SSP by the Social Security Administration.

On May 16, 2002, the San Francisco Superior Court of the State of California ruled that W&I Code section 14005.37 applies to SSI/SSP Medi-Cal beneficiaries discontinued from SSI/SSP. The Department and the CWDs are following the Court approved Implementation Plan setting forth the steps that are to be taken to implement the requirements of W&I section 14005.37. The Department released All County Welfare Directors Letter 03-24 on May 6, 2003, which expands on the previous Medi-Cal redetermination instructions pertaining to SB 87 and the CalWORKs population to also include the discontinued SSI/SSP population. On July 1, 2003, CWDs began processing the backlog of cases that have been eligible since June 2002. **In December 2005, the CWDs completed processing the backlog.**

E 16 (PC-CA)	X	X	County Cost Control

Based on the requirements of the Health Trailer Bill of 2004, the Department, with input from the CWDA, developed a cost allocation plan to limit CWDs' costs associated with Medi-Cal eligibility determinations, beginning in FY 2005-06. The plan included staffing guidelines, policies to control overhead costs, and language that controls wage increases, while still maintaining the integrity of the eligibility determination process. A report of the findings and conclusions was submitted to the Legislature in May 2005.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 17 (PC-OA)	X	X	Merit System Services for Counties

Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. As many counties do not have a civil service system, the Department contracts with the State Personnel Board for Merit System Services to perform as a personnel board for those counties. Merit System Services administers a civil service system for employment and retention of Medi-Cal staff in 30 CWDs and oversight in the other 28 counties. In order to mirror the funding for this service included in the CDSS budget, beginning in FY 2003-04, funds for the contract with Merit System Services are being budgeted in the Department's local assistance budget, rather than in the state support budget where they had previously been budgeted.

E 18 (PC-11)	X	X	Accelerated Enrollment – SCHIP Title XXI

Applications received by the SPE are screened for Medi-Cal eligibility. Effective July 2002, if a child appears to be Medi-Cal eligible without a SOC, the SPE will establish accelerated enrollment for the child and input an eligibility transaction to the State Medi-Cal Eligibility Data System (MEDS) database. Effective October 1, 2003, the 50% federal share of the accelerated enrollment costs is funded from Title XXI, as required by federal statute.

E 19 (PC-CA)	X		PRWORA Funds Availability

The Department has determined that $120,619 in enhanced federal funding for implementation of the provisions of PRWORA of 1996 is still available to the State. PRWORA funds may be used to provide 75% FFP for increased costs associated with Medi-Cal eligibility determinations for the Section 1931(b) program. The funds will offset General Fund costs in 2005-06 associated with the Section 1931(b) program that would otherwise have been matched at 50% FFP.

E 20 (PC-CA)	X	X	IHSS County Administration Costs

Federal regulations require that Medi-Cal eligibility for non-SSI Medicaid beneficiaries be determined by Medicaid eligibility workers using Medi-Cal rules. In twenty counties, applicants for In-Home Supportive Services (IHSS) have their Medi-Cal application and personal care needs assessment determined by IHSS social service workers. The Department instructed counties by an All-County Welfare Directors' Letter (ACWDL) to change their procedures effective August 2004 so that Medi-Cal eligibility and SOC will be determined by Medi-Cal eligibility workers following Medi-Cal rules. IHSS social service workers will complete the personal care needs assessment for the in-home care applicants.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 21 (PC-CA) ~~(PC 12)~~	X	X	Craig V. Bonta Disability Appellants

The Superior Court of San Francisco County in the Craig, et al. v. Bontá, et al. lawsuit requires that the Department continue to provide no share-of-cost, full-scope Medi-Cal benefits to persons who are terminated from SSI/SSP effective June 30, 2002, and after, until county welfare departments (CWDs) redetermine their ongoing eligibility for Medi-Cal. A backlog of 5,138 beneficiaries has occurred because former SSI/SSP beneficiaries who were discontinued for being no longer disabled and who appealed that determination were never placed in a Craig aid code pending the final outcome of their appeal process. The Department notified the CWDs of this group of beneficiaries and instructed the CWDs to conduct the redeterminations by September 2005. CWDs are still in the process of conducting redeterminations for this group of beneficiaries. The Department expects counties to complete the redeterminations for this group of beneficiaries by July 2006.

E 22 (PC-7) (PC-CA)		X	Medi-Cal to Healthy Families (HF) Accelerated Enrollment

The Budget Act and Health Trailer Bill of 2005 require the State to administer the Medi-Cal to HF Accelerated Enrollment program. This program is to be effective on the first day of the third month following the month of federal approval of the State Plan Amendment (SPA) in accordance with Title XIX and Title XXI, or August 1, 2006, whichever is later. Implementation is contingent upon availability of FFP under Title XXI. Accelerated enrollment to HF is only available for children under the age of 19 with Medi-Cal applications received by the county. The county must determine that: 1) the child is eligible for full-scope Medi-Cal with a share-of-cost; 2) the child's income is within the limits established by HF; and 3) the child, parent(s), or guardian has given permission for the application information to be shared. The county shall forward sufficient information to the HF program using an electronic process developed for use in the Medi-Cal to HF Bridge Benefits program. The eligibility period for the accelerated enrollment program will begin the first day of the month that the county finds the child meets the HFP eligibility criteria and ends the last day of the month the child is either enrolled in or found ineligible for the HFP. The Department will not require a feasibility study to implement the MEDS changes and provide the necessary information electronically to the Managed Risk Medical Insurance Board.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 23 (PC-5) (PC-CA)	X	X	Redetermination Form Simplification

The Medi-Cal annual redetermination form (MC 210 RV) is being revised to make it more user friendly, shorter, and easier for beneficiaries to complete. As a result of the changes in the form, more beneficiaries who would have otherwise not completed the form and therefore would no longer be eligible will now complete the annual redetermination process and maintain coverage.

E 24 (PC-CA) X FY 2006-07 Cost of Doing Business

County welfare department administrative costs for Medi-Cal eligibility determinations are expected to increase at the rate of 4.17% for FY 2006-07. The rate of increase is based on California Necessities Index projections. However, county administration salaries and overhead will be frozen at the FY 2005-06 level for FY 2006-07.

E 25 (PC-OA) X Children's Outreach Initiative

Despite increases in Medi-Cal applicants and Healthy Families Program (HFP) enrollment over the past several years, a number of California children continue to have no health care coverage. Many of these children would be eligible for Medi-Cal or HFP, but have not pursued coverage. If the State can persuade families to apply or enroll, the number of children without health care coverage in California would be reduced.

The Department will engage in three activities to increase participation in the public programs:

- County initiatives
- Media campaign
- Toll-free telephone line

The Department will allocate funding to the 20 counties with the greatest number of uninsured children to partner with public and private community organizations for outreach, streamlined enrollment, retention of health coverage, and appropriate utilization of health care; and to 5 to 10 other counties that have established community networks and infrastructures. The media campaign will work in coordination with county outreach to target the families which have children with no health care coverage and are likely to be eligible for the public programs. The Medi-Cal/HFP toll-free line will be augmented to handle the increased volume of calls generated by the media campaign and county initiative activities.

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
E 26 (PC-CA)	**X**	**X**	**Los Angeles County Hospital Intakes** **Los Angeles County uses Patient Financial Services Workers (PFSWs) to process Medi-Cal applications taken in Los Angeles County hospitals. W & I Code Section 14154 limits the reimbursement amount for PFSW intakes to the rate that is applied to Medi-Cal applications processed by the Los Angeles County Department of Social Services eligibility workers. The federal share for any costs not covered by the Department of Social Services rate is passed through to the county. Cases are referred to the County Department of Social Services for case maintenance.**
E 27 (PC-CA)	**X**	**X**	**Eligible Growth** **The county administrative cost base estimate does not include costs anticipated due to the growth in the number of Medi-Cal only eligibles. Funds are added through a policy change item based on the cost impact of the expected growth in the average monthly number of Medi-Cal only eligibles. The number is adjusted with each Estimate with updates of the latest base eligible count. The policy change presumes that counties will hire staff to process the new applications and maintain the new cases.**

BENEFITS: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
B 0.1 (PC-151)		X	Dental Health for Children

The Administration is proposing that school-aged children be required to have dental check-ups.

BENEFITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
B 1 (PC-OA)	X	X	Public Health Nurses for Foster Care

The Budget Act of 1999 included funds for the CDSS to establish a program utilizing foster care public health nurses in the child welfare program to help foster care children gain access to health-related services. The public health nurses are employed by the counties and funded through CDSS General Funds and Title XIX matching funds. The program is administered by the Children's Medical Services Branch in CDHS, via an interagency agreement with CDSS.

B 2 (PC-14)	X	X	Local Education Agency (LEA) Providers

Through the LEA Billing Option, LEAs can become Medi-Cal providers and submit claims for services to Medi-Cal beneficiaries within their jurisdiction. LEA providers may bill retroactively for services rendered up to one year prior to their date of enrollment as long as claims are billed within the statutory billing limit. The Medi-Cal program will provide matching federal funds to the LEAs.

State Plan Amendment 03-024, approved in March 2005, will implement a new methodology for reimbursement in June 2006, retroactive to April 2003. Interim rates based on a rate study will be used for covered LEA services and costs will be reconciled against reimbursements.

B 3 (PC-67)	X	X	Medi-Cal TCM Program

The Targeted Case Management (TCM) program assists Medi-Cal beneficiaries in accessing needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, linkage and consultation, assistance with accessing services, crisis assistance planning, and periodic review. Through rates established in the annual cost reports, local governments claim FFP for these case management services. The existing target populations of Medi-Cal beneficiaries that can receive TCM services are public health, public guardian, linkages, outpatient, adult probation and community.

SB 308 (Chapter 253, Statutes of 2003) redefines Local Governmental Agencies to include Native American Indian tribes. This allows these tribes to participate in the Medi-Cal Administrative Activities (MAA) and Targeted Case Management (TCM) programs. With the augmentation of staff in July 2005, the Department is currently implementing the provisions of this bill.

BENEFITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
B 4 (PC-63)	X	X	Targeted Case Management Services – CDDS Regional center case management services, as provided to eligible developmentally disabled clients via contract with the California Department of Developmental Services (CDDS) and authorized by the Lanterman Act. CDDS conducts a rate study every three years to determine each regional center's actual cost to provide Targeted Case Management (TCM). A unit of service reimbursement rate for each regional center is established. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible. FFP for Medi-Cal eligibles is authorized by a SPA.
B 5 (PC-OA)	X	X	Office of State Long-Term Care Ombudsman CMS has verbally denied federal Title XIX funding for administrative functions used to support additional ombudsman services to residents in skilled nursing facilities (SNFs) and Distinct Part SNFs of acute care hospitals. The California Department of Aging will appeal the CMS decision. The California Ombudsman program is regulated by Chapter 11 of the Older Californians Act, beginning with Section 9700 of the Welfare and Institutions Code. The office recruits, train, and directs the activities of over 1,300 volunteers assigned to act as advocates for the residents of nursing facilities (NFs), distinct-part NFs, and residential care facilities for the elderly (RCFEs).
B 6 (PC-OA)	X	X	Disease Management Program Welfare and Institutions Code Section 14132.27 requires the Department to apply for a federal waiver to test the efficacy of providing a disease management benefit to fee-for-service Medi-Cal beneficiaries. The effectiveness of this benefit includes demonstration of the cost neutrality of the Disease Management Waiver. To achieve this goal, the Department will enter into contracts with one or more disease management organizations and an independent evaluation contractor. The Disease Management Program is scheduled to begin in ~~May~~ **October** 2006.

BENEFITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
B 7 (PC-OA)	X	X	Medi-Cal Administrative Activities

AB 2377 (Chapter 147, Statutes of 1994) authorizes the State to implement the Medi-Cal Administrative Claiming process. The Medi-Cal program will submit claims on behalf of local governmental agencies (LGAs) to obtain FFP for Medicaid administrative activities necessary for the proper and efficient administration of the Medi-Cal program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of Medi-Cal services.

Section 105 of AB 2780 (Chapter 310, Statutes of 1998), allows school districts the option of claiming Medi-Cal Administrative Activities through their local educational "consortium" (LEC), or through the LGA.

Both LGAs and LECs may amend prior year contracts up to the two-year retrospective federal claiming limitation. Prior year contract amendments are generated when additional funds, such as special local initiatives and Proposition 10 funds, are made available as the certified public expenditure.

SB 308 (Chapter 253, Statutes of 2003) redefines Local Governmental Agencies to include Native American Indian tribes. This allows these tribes to participate in the Medi-Cal Administrative Activities (MAA) and Targeted Case Management (TCM) programs. With the augmentation of staff in July 2005, the Department is currently implementing the provisions of this bill.

BENEFITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
B 8			Home and Community-Based Services Waivers
			SB 2012 (Chapter 94, Statutes of 1982) added home and community-based services to Medi-Cal when federal waivers are granted.
(PC-53)	X	X	A. Home and Community Based Services – **C**DDS

On September 28, 2001, CMS renewed the DD waiver for a five-year period, October 1, 2001, through September 30, 2006. The approval allows an increase in waiver enrollment from 35,000 to 50,754 persons over five years. On February 3, 2003, CMS approved an amendment request to increase the waiver enrollment cap from 50,754 to 70,000 in increments of 5,000 per year for four years, beginning with Waiver Year 2002-03. The effective date of this amendment is October 1, 2002. On May 3, 2004, CMS granted permission to add specialized therapeutic services (for 21 years of age and older), which consists of special oral health, behavioral health and physical health services effective October 1, 2002, through September 30, 2006. On June 15, 2004, CMS approved the amendment that reflects statutory revisions that transfers all responsibilities for administration of the habilitation services program for person with developmental disabilities effective July 1, 2004, from the California Department of Rehabilitation to CDDS.

On August 24, 2004, CMS approved an amendment for a new service entitled "voucher respite care". Under this option, adult consumers or family members can elect to utilize vouchers provided by the servicing regional center to directly obtain respite services. This is in addition to the waiver's existing respite services wherein respite caregivers are employed by State-approved community care facilities utilizing a procurement process. CDDS began billing for this service effective December 1, 2004. The waiver renewal application ~~is being developed and the Department anticipates that the application~~ will be submitted to CMS in ~~April~~ **May** 2006. The renewal will be effective from October 1, 2006 through September 30, 2011.

The enrollment cap for the first year of the waiver is estimated to be 75,000, and the cap will increase to 87,000 by the fifth year. The FY 2006-07 estimate includes a 3% provider rate increase to be effective July 1, 2006.

BENEFITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
(PC-16) (PC-OA)	X	X	B. Multipurpose Senior Services Program – CDA On April 9, 2004, CMS approved the renewal of the Multipurpose Senior Services Program (MSSP) Waiver, for the period of July 1, 2004 through June 30, 2009. MSSP provides waiver services to individuals 65 years or older who are Medi-Cal eligible and who, in the absence of this waiver and as a matter of medical necessity, would otherwise require care in a nursing facility. MSSP is operated by the California Department of Aging with mandated CDHS oversight.
(PC-NA)	X	X	C. NF-A and NF-B Level of Care Waiver CMS approved the renewal of the Nursing Facility A and B (NF A/B) Level of Care Waiver for a five-year period effective January 1, 2002 through December 31, 2006. The renewed NF A/B Waiver has a maximum enrollment capacity of 890. ~~For 2005, the NF A/B waiver has a reached a maximum enrollment capacity of 780. All waiver slots are currently filled, and there are~~ **As of January 2006, all NF A/B waiver slots are filled. Currently, 584 individuals are receiving services, 306 individuals are being assessed for enrollment and** over 600 individuals **are** on the waiting list. **The Department is working closely with CMS to resolve current cost neutrality issues with the NF-A/B Waiver, and plans to submit a waiver renewal application to CMS by June 30, 2006 that would combine the current In-Home Medical Care, Nursing Facility Subacute, and Nursing Facility Level A/B HCBS Waivers. The combined waiver would have a five-year term, from January 1, 2007 through December 31, 2011 and would continue to provide safe and appropriate home care to waiver beneficiaries in lieu of long-term institutional placement**.
(PC-NA)	X	X	D. Nursing Facility Subacute Waiver This waiver includes services identical to the NF A/B waiver, but serves eligible consumers who would otherwise reside in nursing facilities at the adult/pediatric sub-acute level of care. CMS approved a request for a five-year renewal of this Waiver effective April 1, 2005 through March 31, 2010. **The Department proposes to combine this waiver with the NF A/B Level of Care Waiver and In-Home Medical Care Waiver effective January 1, 2007.**

BENEFITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
(PC-NA)	X	X	**E. In-Home Medical Care Waiver** **On December 19, 2003, CMS renewed the In-Home Medical Care (IHMC) services waiver for a five-year period effective July 1, 2003, through June 30, 2008. The IHMC waiver provides in-home medical care to physically disabled Medi-Cal beneficiaries who would, in the absence of this waiver, meet the criteria for hospital care for at least ninety consecutive days. Persons requiring these services would have substantial needs over a 24-hour period. The Department proposes to combine this waiver with the NF A/B Level of Care Waiver and Nursing Facility Subacute Waiver effective January 1, 2007.**
(PC-NA)	X	X	**F**. AIDS Waiver This waiver serves Medi-Cal eligible AIDS patients who otherwise would need ~~ICF,~~ NF or acute hospital care. This waiver was approved by CMS with an effective date of January 1, 1989, and clients began receiving services in early June 1989. The AIDS waiver was renewed for the term January 1, 2002, through December 31, 2006. ~~Effective January 1, 2002, the geographic area serviced by the AIDS waiver was expanded to include Del Norte, and San Benito Counties.~~ The Department anticipates submitting a renewal waiver application no later than June 30, 2006. This renewal will be effective from January 1, 2007 through December 31, 2011.
B 9 (PC-OA)	X	X	Health-Related Activities Health-related activities are services that aid Medi-Cal eligibles to gain access to medical services or to maintain current levels of treatment. Title XIX federal funds are passed through to CDSS for health-related activities performed by social workers in the counties.

BENEFITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
B 10 (PC-82)	X	X	Waiver Personal Care Services

AB 668 (Chapter 896, Statutes of 1998) required Medi-Cal to add personal care services to the Nursing Facility A and B Level of Care (NF A/B) and Nursing Facility Subacute (NF SA) Waivers. On September 23, 2004, CMS approved an amendment effective April 1, 2004, renaming the benefit "Waiver personal care services" to "Home and Community-Based Services Personal Care (HCBSPC)". HCBSPC is one option on the menu of services that waiver participants may choose from, to the extent that waiver cost neutrality is assured. This benefit was redefined to include services that differ from those in the State Plan, and that help support a beneficiary's choice to remain in the home and community. There is no longer a requirement that waiver consumers receive the maximum of 283 hours of State Plan Personal Care Services (SPPCS) prior to receiving HCBSPC. However, waiver consumers must be receiving some amount of SPPCS to be eligible for HCBSPC. These services are provided through the counties' IHSS programs, and will be paid via an interagency agreement with CDSS or are provided by home health agencies.

B 11	(PC-48) (PC-OA)	X	X	Personal Care Services

As of April 1993, the Medi-Cal program has covered personal care services as a benefit. This is accomplished by making Title XIX funds available to the In-Home Supportive Services (IHSS) Program under the administrative control of CDSS. The Department still retains authority over the provider reimbursement rates.

CMS has revised its interpretation of the State Plan Personal Care Services Program (PCSP) to include protective supervision and domestic and related services, effective August 1, 2004. The Terms and Conditions of the new IHSS Plus Waiver include the authority for a one-time claim of retroactive FFP for these services as State Plan PCSP services. The retroactive claiming is limited by 1) the amount of FFP that would have been claimed if the new waiver, with protective supervision and domestic and related services included, had been approved effective May 4, 2004, through the actual effective date of August 1, 2004; and 2) the allowable two-year retroactive federal claiming period. After August 1, 2004, protective supervision and domestic and related services will be ongoing State Plan PCSP services. The retroactive claiming was fully funded in 2004-05.

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
B 12	(PC-13) (PC-OA)	X	X	Adult Day Health Care – CDA

Adult Day Health Care (ADHC) is a community-based day program providing a variety of health, therapeutic, and social services designed to serve those at risk of being placed in a nursing home. ADHC became an optional Medi-Cal benefit in 1978. ADHC rates, which are set at 90% of the NF-A weighted average rate, increased by 5.72% effective August 1, 2005.

In December 2003, CMS notified the Department that ADHC must be approved under a waiver or State Plan Amendment (SPA), with specified changes to the program in order to continue receiving federal funding. The Department is working with CMS and CDA to develop the SPA or waiver, and implementation is anticipated by Spring of 2008.

B 13 (PC-25) X Adult Day Health Care Reforms

The Governor's Budget proposes to institute several adult day health care (ADHC) reforms. The reforms are:

- Unbundling of the current all-inclusive ADHC procedure code into its component services. The current rate of 90% of the NF-A rate, set by a 1993 court settlement, would remain the maximum rate per day, but each service would be assigned a separate procedure code and rate. Only the bundled procedure code that includes the ADHCs' overhead and unskilled services would require prior authorization, and ADHCs would "bill direct" for ancillary and skilled services.
- Tightening medical criteria so that only those recipients that truly require specific services can receive authorization for ADHC.
- Performance of post-payment ~~audits~~ **reviews** of participant charts by CDA during their regular surveys to ensure that services billed were actually provided and were medically necessary, and recoup inappropriate payments from the ADHCs.
- Add Medi-Cal field office staff to do on-site approvals of requests for prior authorization, to allow review of patients' medical record.

BENEFITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
B 14 (PC-23)	X	X	SCHIP Funding for Prenatal Care

In order to maximize revenues, the Budget Act and Health Trailer Bill of 2005, require MRMIB to file a SPA in the SCHIP to claim 65% federal funding for prenatal care provided to women currently ineligible for federal funding for this care. The cost for this care is currently 100% General Fund. The SPA which was filed on June 30, 2005 will allow SCHIP funding to be claimed for both 2004-05 and 2005-06 in 2005-06. Funding will be claimed for undocumented women, and for legal immigrants who have been in the country for less than five years. ~~CMS (which has 90 days to approve, disapprove, or request additional information when a SPA is filed) requested additional information in November; therefore, the 90-day review period has been stopped.~~ **CMS approved the SPA in March 2006.**

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
B 15	(PC-19) (PC-FI)	X	X	*Conlan~~, Schwarzmer, Stevens~~ v. Bontá* **; *Conlan v. Shewry***

On September 30, 2002, the appellate court ruled in *Conlan v. Bonta* (2002) 102 ~~C.A.~~**Cal.App.**4th 745, (*Conlan I*) that the State had violated 42 U.S.C. section 1396a(a)(10)(B) (the Medicaid comparability provision) because the State did not have a reasonable procedure for promptly reimbursing Medi-Cal beneficiaries for covered services for which they paid during the three months prior to applying for Medi-Cal coverage. The appellate court held that the Department must adopt and implement procedures consistent with the opinion to ensure that Medi-Cal beneficiaries entitled to reimbursement for covered services obtained during the retroactivity period, and for co-payments during the post eligibility period (if the Department is "obligated to pay") are promptly reimbursed. The appellate court remanded the case to the trial court to issue a writ consistent with the decision. The petitioners filed a motion to enforce the appellate court decision. The court found in petitioners' favor on nearly all issues and issued its interim order on May 12, 2003, requiring the Department, inter alia, to submit a Plan of Compliance within 60 days.

On July 11, 2003, the Department submitted the proposed Compliance Plan and incorporated it into a Motion to Approve. On March 3, 2004, the superior court issued an order denying the Motion to Approve the Department's Compliance Plan. The Department appealed this order. ~~On November 20, 2003, CMS advised the Department in writing that FFP for direct reimbursement to beneficiaries was available under State Medicaid Manual section 6320 only in limited circumstances. The Department has argued that the proposed Plan will provide direct reimbursement only when FFP is available as authorized by CMS.~~

In *Conlan v.* Shewry ~~___ Cal. Rptr. 3d ___,2005 WL 1941320, Cal.App. 1 Dist., Aug. 15, 2005)~~ **(2005) 131 Cal.App.4th 1354** (*Conlan II*), the court addressed five key issues relevant to the Plan's implementation. The court held that the Department is required to: 1) send notice of the new monetary reimbursement process available to all current and former Medi-Cal beneficiaries who may have claims arising on or after June 27, 1997; 2) provide monetary reimbursement to any individual who has a valid claim for reimbursement arising on or after June 27, 1997; 3) provide reimbursement for claims arising from the date an application for Medi-Cal benefits is submitted to the date that the application is granted; 4) provide reimbursement for services rendered by non-Medi-Cal providers if the services were provided during the retroactivity period; and 5) reimburse the beneficiary the amount paid by the beneficiary, not to exceed the rate established for that service under the Medi-Cal program.

~~The Department will submit a modified Plan consistent with the court's decision to the lower court.~~ **As ordered, the Department submitted a**

BENEFITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

revised Plan to the trial court. On February 8, 2006, after hearing objections to the revised Plan, the trial court issued an order that requires the Department to make additional changes to the Plan and beneficiary notice. In order for the court to approve the Plan, the Department must include a detailed description of the steps it will take to "ensure" beneficiaries are reimbursed by the provider for payments even in excess of the Medi-Cal maximum rate. The court also ordered the Department to include a multilingual statement with the beneficiary notice that informs non-English speakers about how to get assistance with notice translations.

At a hearing held on May 4, 2006, the court ordered that the reimbursement process must include reimbursement for any expenses incurred after Medi-Cal eligibility is established. Additionally, the court ordered that the reimbursement process must cover erroneous share-of-cost calculations. The Department is considering whether to appeal the order.

Also at the May 4, 2006 hearing, the court ordered that the Department must have the reimbursement process fully implemented and "checks going out the door," by no later than October 2, 2006. Failure to meet this deadline would result in contempt sanctions issued by the court against the Department.

~~The Department is currently developing a process through the Medi-Cal dental fiscal intermediary to ensure prompt reimbursement to the beneficiaries, once the final court decision is reached.~~

EDS **and Delta Dental** ~~will develop~~ **are developing** and ~~implement~~ **implementing** new processes to assist beneficiaries **(both fee-for-service and managed care)** and adjudicate and track claims to ensure prompt reimbursement. EDS **and Delta Dental** will be required to hire, train and oversee appropriate staff to address this new workload. Staff will include telephone operators, business analysts, suspense examiners, cash control staff, and print center personnel.

BENEFITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
B 16 (PC-26)	~~X~~	X	Fluoride Varnish

The Department will implement a Medi-Cal program policy change in ~~February~~ **July** 2006 to enable the earlier prevention of tooth decay by adding coverage for fluoride varnish provided by physicians. Fluoride varnish is better tolerated by infants and toddlers than other topical fluorides, with less toxicity and risk of adverse reaction because less of the product is used and application is easier and faster. Because dentists do not routinely see mothers and children under the age of six, medical providers, who do routinely see pregnant women and young children, can intervene earlier to prevent childhood tooth decay.

B 17 (PC-48)	X	X	In-Home Supportive Services Plus §1115 Waiver Demonstration Program

The Department submitted a federal Medicaid §1115 demonstration waiver application to CMS in May 2004 to cover previously county and state-funded In-Home Supportive Services (IHSS) Program costs under Medi-Cal. The waiver was approved ~~and implemented on~~ **for the period of** August 1, 2004 **through July 30, 2009**. When recipients have any unit of personal care service provided by a parent/spouse, are cashed out for a restaurant meal (in lieu of meal preparation), or are cashed out through the advance pay option, all of their personal care services are covered under the waiver. The demonstration waiver enables federal financial participation for both allowable services and waiver administration.

The state funded IHSS residual program now covers only in-home services for individuals not eligible for federally funded full-scope Medi-Cal coverage.

BENEFITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
B 18 (PC-22)	X	X	CDSS Share of Cost Payment for IHSS

The California Department of Social Services (CDSS) and the California Department of Health Services (CDHS) have implemented a process that enables Medi-Cal In-Home Supportive Services (IHSS) recipients who have a Medi-Cal share-of-cost (SOC) higher than their IHSS SOC to be eligible for Medi-Cal at the beginning of each month. Each IHSS recipient with a Medi-Cal SOC that exceeds his/her IHSS SOC must meet the Medi-Cal SOC obligation to establish Medi-Cal eligibility.

Prior to the complete automation of the Case Management, Information, and Payrolling System (CMIPS), the IHSS chore service worker payroll computer system, an interim process has begun to reconcile the difference between the IHSS and Medi-Cal SOCs, where the Medi-Cal SOC exceeds the IHSS SOC, and to allow the IHSS recipients to access Medi-Cal eligibility on the first day of each month. An Interagency Agreement between CDSS and CDHS has established the process for the transfer of CDSS funds to prepay the Medi-Cal SOC for IHSS recipients.

When CMIPS is fully automated, CDSS will only fund services for each IHSS recipient in an amount equal to the difference between the monthly Medi-Cal SOC and the IHSS SOC.

FAMILY PACT: NEW ASSUMPTIONS

Applicable F/Y	
C/Y	B/Y

FAMILY PACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FP 1 (PC-1)	X	X	Family Planning Initiative (Family PACT)

Originally implemented as a state-only program in 1997, Family PACT became a Section 1115 demonstration project effective December 1, 1999. It provides family planning services to eligible, uninsured Californians with income at or below 200% of poverty. FFP at 90% has been assumed for family planning services and testing for sexually transmitted infections (STIs). The Federal Medical Assistance Percentage (FMAP) has been assumed for treatment of STIs and other family planning companion services. No FFP has been **previously** assumed for sterilizations and the treatment of some family planning-related medical conditions, including inpatient care for complications from family planning services. Costs for undocumented persons (currently assumed to be 13.95% of the Family PACT expenditures in 2005-06 and 17.79% in 2006-07) have been budgeted at 100% GF. Family PACT Waiver drugs will be included in the Medicaid Drug Rebate Program.

The current waiver expired on November 30, 2004. An extension through ~~December 31, 2005~~ **May 31, 2006**, has been granted by CMS. **Subsequent extensions will be in one-month increments.** On May 27, 2004, the Department submitted an application for a three-year period. The renewal request is currently being evaluated by CMS.

FP 2 (PC-OA)	X	X	Family PACT Medicaid Waiver Demonstration Evaluation

An important component of the Family PACT Medicaid Waiver Demonstration Project is evaluating the effectiveness of the program. The University of California, San Francisco conducts the program evaluation. The evaluation includes, but is not limited to, analyzing: the changes in birth rates; access by targeted populations; change in provider base for targeted geographical areas; provider compliance; claims analysis; and the cost effectiveness of the services.

A contract to provide data for the Family PACT evaluation was negotiated for a five year term beginning July 1, 2005.

FP 3 (PC-OA)	X	X	Family PACT Provider Education – Support Services

DHS statewide support services consist of services to the Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to: public education and awareness; provider enrollment, recruitment and training; training and technical assistance for medical and non-medical staff; education and counseling services; and preventive clinical services. The Office of Family Planning contracts with a variety of entities to provide these services. The costs are projected for the duration of the Family PACT Waiver Demonstration Project.

FAMILY PACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FP 4 (PC-FI)	X	X	Family PACT Materials Distribution

An important component of the Family PACT Program is the distribution of client education materials to approximately 2,700 providers. The state, through the fiscal intermediary, has the responsibility to develop, print, purchase, and distribute over 150 different publications.

FP 5 (PC-FI)	X	X	Family PACT Systems

The establishment of the Family PACT Waiver Demonstration Project and the expansion to include additional services required fiscal intermediary systems enhancements and modifications. The system changes have been made and are ongoing, as required for program maintenance.

FP 6 (PC-126)	X	X	Family PACT Drug Rebates

The Department collects rebates for family planning drugs covered through the Family PACT program.

The Department began invoicing for Family PACT drug rebates on June 7, 2001. These invoices covered all quarters back to December 1, 1999.

FP 7 (PC-OA)	X	X	Family PACT Male Involvement, I&E and TSO Programs

The Health Trailer Bill of 2003 requires the Department to require contractors and grantees under the Office of Family Planning, Male Involvement Program (MIP), Information and Education (I&E) Program and Teen Smart Outreach (TSO) Program, to establish and implement a clinical services linkage to the Family PACT program, effective in the 2003-04 fiscal year.

FP 8 (PC-OA)	X	X	Family PACT HIPAA Privacy Practices Beneficiary Notification

Under the federal HIPAA, it is a legal obligation of the Medi-Cal program to provide a NPP to each Family PACT beneficiary explaining the rights of beneficiaries regarding the protected health information created and maintained by the program. Medi-Cal has an ongoing responsibility to provide this Notice to all new enrollees, and inform all beneficiaries about how to get a copy of this Notice at least every 3 years, or whenever a substantial change is made to the Notice. Due to confidentiality concerns, distribution of the NPP to these beneficiaries ~~will be~~ **is** accomplished by distribution at the clinic. This assumption is to cover the cost of printing and mailing the NPPs to the clinics.

FAMILY PACT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FP 9 (PC-102)	X	X	Family PACT Sterilization Policy

The Department ~~is revising~~ **revised** the sterilization policy to conform with Federal guidelines to draw down 90% FFP for sterilization procedures (~~currently~~ **previously** 0% FFP). The new guidelines are ~~expected to be~~ in place ~~by~~ **as of** ~~July 1,~~ **February 1,** 2006.

FP 10 (PC-124)	X	X	Family PACT 5% Provider Payment Decrease

The Budget Act and Health Trailer Bill of 2003 reduced selected provider payments by 5%, effective January 1, 2004. Acute hospital inpatient services, federally qualified health centers, rural health clinics, outpatient services billed by a hospital, and clinical laboratories were exempted from the payment reductions. ~~The Department had been temporarily enjoined by federal court order~~ **A federal court issued a preliminary injunction in December 2003 that prohibited the Department** from implementing this payment reduction in fee-for-service Medi-Cal. The Department ~~won its appeal in~~ **appealed and on** August **2,** 2005**, the United States Court of Appeals for the Ninth Circuit reversed the federal court preliminary injunction. On November 30, 2005, the Court of Appeals denied the plaintiffs' request for rehearing. Thus, the Department was no longer enjoined from implementing the payment reduction.** AB 1735 (Chapter 719, Statutes of 2005) amended the implementation date from January 1, 2004, to January 1, 2006. The 5% payment reduction ~~expires~~ **was to have expired on** December 31, 2006.

The payment reduction was implemented on January 1, 2006. With the subsequent passage of SB 912 (Chapter 8, Statutes of 2006), the reduction ended on March 3, 2006, and payments were no longer reduced beginning March 4, 2006.

Effective September 1, 2004, reimbursement of prescription and over-the-counter drugs dispensed by pharmacy providers was exempted from this reduction due to implementation of the pharmacy payment reduction on that date.

BREAST AND CERVICAL CANCER TREATMENT: NEW ASSUMPTIONS

Applicable F/Y	
C/Y	B/Y

BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
BC 1 (PC-2)	X	X	Breast and Cervical Cancer Treatment Program

The Budget Act of 2001 includes funding for the creation of the BCCTP effective January 1, 2002, for individuals with a diagnosis of breast and/or cervical cancer who need treatment and have income under 200% of FPL. Enhanced Title XIX funding is claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope, no cost Medi-Cal benefits for the duration of treatment for women under age 65 who are citizens or immigrants with satisfactory immigration status and who have no other health coverage. The BCCTP also includes a **100%** state ~~only~~ **funded** program that provides cancer and cancer-related treatment services only. Coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. Women with inadequate health coverage, undocumented women, and males are eligible for the state-only program. Undocumented women under age 65 are also eligible for federally funded emergency**, state-only pregnancy-related and long-term care** services for the duration of their cancer treatment.

Enrollment of BCCTP applicants is performed by Centers for Disease Control (CDC)-approved screening providers**, which in California are Every Woman Counts and Family PACT Program providers,** using an electronic Internet-based application form. Those women who appear to meet federal eligibility requirements receive immediate temporary full-scope no cost Medi-Cal coverage under accelerated enrollment. DHS Eligibility Specialists (ES) review the Internet-based application forms and determine regular BCCTP eligibility under the state and federal components. The ES may need to request additional information from the applicant to determine appropriate eligibility under the BCCTP.

~~County organized health systems added coverage for BCCTP eligibles in February 2002. Two-plan models and geographic managed care plans also added coverage in February 2002 for continuation of care only. Interim rates equal to the disabled rate have been used until determination of the final rates could be made. CalOPTIMA implemented the final BCCTP rate effective October 1, 2003. Final rates for all other plans are in the process of negotiation. Retroactive rate adjustments will be made when the final rates have been determined.~~ **Current managed care rates fully incorporate BCCTP costs.**

BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
BC 2 (PC-2)	X	X	Breast and Cervical Cancer Treatment Program – Premium Payment

Effective January 1, 2002, under the **100%** state ~~only~~ **funded** portion of the Breast and Cervical Cancer Treatment Program funded by the Budget Act of 2001, the Department began payment of the premium cost for individuals with breast and cervical cancer who have other health insurance but are underinsured. The criteria for participation in the **100%** state ~~only~~ **funded** premium payment program include the following:

- Family income at or below 200% of FPL **as determined by the enrolling provider**
- California resident
- Other health coverage with premiums, deductibles and copayments exceeding $750 ~~annually~~ **in a 12-month period beginning from the month in which the Eligibility Specialist commences the eligibility determination**
- Diagnosis of breast and/or cervical cancer and in need of treatment
- Not eligible for full-scope, no cost Medi-Cal

BC 3 (PC-OA) X X BCCTP Postage and Printing

Postage and printing costs related to the eligibility determination process for the Breast and Cervical Cancer Treatment Program ~~will be~~ **are** budgeted in local assistance. Costs for the State-funded component of the program ~~will be~~ **are** 100% General Fund**,** and are included in the Postage and Printing policy change. Mailings include letters sent to applicants to request additional information, as well as notices of approval or denial of eligibility.

BC 4 (PC-6) X X BCCTP Retroactive Coverage

Due to the receipt of additional staffing, the Department ~~will be able to begin~~ **began** processing requests for the three months of retroactive BCCTP coverage that are available under federal law for persons who met federal eligibility requirements in the months for which retroactive coverage is requested.

BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
BC 5 (PC- 124)	X	X	BCCTP Provider 5% Payment Decrease

The Budget Act and Health Trailer Bill of 2003 reduced selected provider payments by 5%, effective January 1, 2004. Acute hospital inpatient services, federally qualified health centers, rural health clinics, outpatient services billed by a hospital, and clinical laboratories were exempted from the payment reductions. ~~The Department had been temporarily enjoined by federal court order~~ **A federal court issued a preliminary injunction in December 2003 that prohibited the Department** from implementing this payment reduction in fee-for-service Medi-Cal. The Department ~~won its appeal in~~ **appealed and on** August **2,** 2005**, the United States Court of Appeals for the Ninth Circuit reversed the federal court preliminary injunction. On November 30, 2005, the Court of Appeals denied the plaintiffs' request for rehearing. Thus, the Department was no longer enjoined from implementing the payment reduction.** AB 1735 (Chapter 719, Statutes of 2005) amended the implementation date from January 1, 2004, to January 1, 2006. The 5% payment reduction ~~expires~~ **was to have expired on** December 31, 2006.

The payment reduction was implemented on January 1, 2006. With the subsequent passage of SB 912 (Chapter 8, Statutes of 2006), the reduction ended on March 3, 2006, and payments were no longer reduced beginning March 4, 2006.

Effective September 1, 2004, reimbursement of prescription and over-the-counter drugs dispensed by pharmacy providers was exempted from this reduction due to implementation of the pharmacy payment reduction on that date.

REDESIGN: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

REDESIGN: OLD ASSUMPTIONS

	Applicable F/Y	
	C/Y	B/Y

Medi-Cal Redesign

The Budget Act of 2005 includes redesign of the Medi-Cal Program. The key elements include:

- Expansion of managed care.
- Restructuring hospital financing. (See Medi-Cal Hospital/Uninsured Care Demonstration section.)
- Aligning the dental benefit package with that of commercial plans by implementing a $1,800 annual cap on dental benefits for adults.

The components of Medi-Cal Redesign with fiscal impacts in FY 2005-06 and FY 2006-07 are included in this section.

RD 1 (PC-24) (PC-FI) X X $1,800 Dental Cap for Adults

As part of Medi-Cal Redesign, the Budget Act of 2005 includes efforts to align the Medi-Cal dental benefit with that of employer-based dental services. This redesign would limit or cap dental services to all adults up to $1,800 per calendar year, excluding:

- Emergency dental services;
- Federally mandated services, including pregnancy-related services;
- Dentures
- Maxillofacial and complex oral surgery; and
- Maxillofacial services, including dental implants and implant-retained prostheses.
- **Long-term care beneficiaries that have long term care aid codes (13, 23, 53 or 63) or reside in either a skilled nursing facility or an intermediate care facility.**

The Dental FI contractor will be required to augment staffing and modify the CD-MMIS to accommodate this policy and process changes to implement the $1,800 cap by January 1, 2006. The cap will result in savings beginning in ~~FY 2005-06~~ **FY 2006-07**.

MEDICARE MODERNIZATION ACT OF 2003: NEW ASSUMPTIONS

	Applicable F/Y	
	C/Y	B/Y

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) was signed into law by the President on December 8, 2003. The purpose of this statute is to provide a prescription drug benefit to all Medicare beneficiaries. Since the Medi-Cal program covers those beneficiaries that have eligibility for both Medi-Cal and Medicare (dual eligibles), this statute will have a significant fiscal impact on the program. The Medicare drug benefit ~~will be effective~~ **began** January 1, 2006. The fiscal effects began in FY 2003-04 and have continued through subsequent fiscal years. There are a number of changes in the new law that will affect the Medi-Cal program.

MM 0.1(PC-42) (OA-42) X X

MMA System-Generated Notice of Action

Beginning January 1, 2006, Medi-Cal beneficiaries who are newly entitled to the Medicare Part D prescription drug benefit must be notified of the reduction in their Medi-Cal benefits. Medi-Cal is required to pay for prescription drugs until the individual has received a 10-day Notice of Action. Due to a lag in the Medicare eligibility determination, it could take up to two months for the notice to be sent.

MEDICARE MODERNIZATION ACT OF 2003: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MM 1 (PC-28)	X	X	MMA – Part D Drug Benefit

The primary payer of dual eligibles' drug coverage ~~will be~~ **has been** moved from Medi-Cal to Medicare Part D. ~~After~~ **As of** January 1, 2006, the states ~~will not~~ **no longer** receive FFP for the purchase of drugs that are covered under Part D. Dual eligible beneficiaries ~~will~~ **are to** be automatically enrolled into Part D drug plans ~~on January 1, 2006~~. If dual eligibles choose to disenroll from Part D, they will be without drug coverage.

MM 2 (PC-57) X X MMA –Phased-Down Contribution

The federal government requires a phased down contribution (clawback) from the states based on an estimate of the cost the state would have incurred for continued coverage of prescription drugs for dual eligibles under the Medi-Cal program. In 2006, the "clawback" will be 90% of this cost estimate and will gradually decrease and be fully phased-in at 75% of the cost estimate in 2015.

MM 3 (PC-FI) X X MMA – Adjudicated Claim Lines Reduction

When the MMA ~~is~~ **was** implemented in January 2006, ~~all~~ dual Medicare/Medi-Cal eligibles ~~will receive~~ **began receiving** most of their prescription drugs through Medicare. This ~~will cause~~ **caused** a decrease in the number of drug adjudicated claims lines beginning in 2005-06. That reduction is reflected in the fiscal intermediary estimate.

MM 4 (PC-87) X X MMA – Cessation of Medicare HMO Premiums

The Department has been paying the monthly premium for dual Medi-Cal/Medicare eligibles enrolled in Health Maintenance Organizations, as it has been cost-effective to have their pharmacy costs paid by these plans. The Department has determined that, because of the implementation of the Medicare Part D drug benefit, it will no longer be cost effective to pay these premiums after Part D begins on January 1, 2006. Therefore, the Department will no longer pay for these premiums after December~~,~~ 2005.

MM 5 (PC-OA) ~~X~~ X MMA – DSH Annual Independent Audit

MMA requires an annual independent certified audit that primarily certifies:

(1) The extent to which Disproportionate Share Hospitals (DSH) (approximately 150+ hospitals) have reduced their uncompensated care costs to reflect the total amount of claimed expenditures.
(2) That DSH payment calculations of hospital-specific limits include all payments to DSH hospitals, including supplemental payments.

MEDICARE MODERNIZATION ACT OF 2003: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MM 6 (PC-54)	X	X	MMA – Managed Care Capitation Savings The implementation of Medicare Part D coverage will result in lower managed care capitation payments for managed care plans for the pharmaceutical services to be covered under Part D for the dual eligible enrollees in the Aged, Blind, Disabled, and Long Term Care groups. Adjustments in the rates will be made effective January 1, 2006.
MM 7 (PC-15)	X	X	Medi-Cal Continuation of Part D Excluded Drug Coverage Medicare Part D Drug Coverage ~~will exclude~~ **excludes** some drugs or classes of drugs that Medi-Cal currently covers for all Medi-Cal beneficiaries. In order to provide comparable coverage to all Medi-Cal beneficiaries, including dual eligibles, Medi-Cal ~~will continue~~ **continues** to cover the following drugs/classes of drugs that are excluded from Medicare Part D: drugs for anorexia, weight loss, weight gain; barbiturates; and benzodiazepines. FFP is available for these drugs/classes of drugs.
MM 8 (PC-OA)	X	~~X~~	MMA – Beneficiary Outreach The Department ~~will distribute~~ **distributed** several mailings to the dual eligible population to inform them of the Medicare Part D drug benefit and to reinforce for the dual eligibles the need to enroll in a Part D plan during the Fall of 2005. **Mailings will continue into the Spring of 2006 to notify beneficiaries who are not full-benefit dual eligibles to enroll prior to June 2006.**
MM 9 (PC-FI)		X	MMA – Provider Relations Provider relations is an essential component of the activities relating to the implementation of the Medicare Modernization Act. Additional provider relations resources are required at EDS to support the major change in pharmacy benefits for dually eligible beneficiaries and the providers who serve them. During the development and implementation phases, providers and other trading partners will need to be notified of the changes made in CA-MMIS. Additional EDS staffing will also be necessary to provide training and offer telephone assistance and clarification on CA-MMIS and claims processing changes. There will also be costs for printing, postage and other costs of provider notification and education including provider bulletins, notices via mail, and the Internet. On a cash budgeting basis, payments will be made beginning in FY 2005-06.

MEDICARE MODERNIZATION ACT OF 2003: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MM 10 (PC-OA)	X	X	MMA – Eligibility Systems Changes

The Department will enter into ~~a contract~~ **contracts** for eligibility systems changes necessary to implement MMA. Medi-Cal processing must be modified to ensure proper identification, tracking and reporting of the recipient population to be covered by Medicare Part D.

- The Medi-Cal Eligibility Data System (MEDS), which maintains eligibility information for the over six million current beneficiaries, will require modification to identify the individuals with the Medicare Part D coverage on the database (likely using a new Medicare Status Code and prescription drug plan (PDP) code) to allow for proper processing and reporting of recipients with the new prescription drug coverage.

- The Fiscal Intermediary Access to Medi-Cal Eligibility (FAME) file, an extract of payment-related eligibility data from MEDS provided to EDS (the Fiscal Intermediary) for claims payment processing, will require modifications to ensure the new Part D coverage is properly identified on the records for the impacted population.

- CMS requires the State to submit a monthly file of dual eligibles for verification processing. This file will be the basis for the monthly phased-down state contribution payment to CMS. A new process will be required to capture Medicare Part D eligibility data from MEDS and create the verification file (per CMS standards) for CMS processing. In addition, the current process for electronic data exchange will require modification and testing to allow the new file to be exchanged.

- CMS will generate a monthly return file to the State. A new process will be required to capture Medicare Part D eligibility information and plan codes from the return file and insert the information into appropriate fields on MEDS.

- CMS will generate a new monthly file containing individuals it believes may be eligible for Medicare Savings Programs (MSP). Systems changes will be needed to systematically send MSP applications to these individuals.

MEDICARE MODERNIZATION ACT OF 2003: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MM 11 (PC-FI)	X	X	MMA – TAR Reductions

Because the Medicare program will provide prescription drug coverage for Medicare/Medi-Cal dual eligibles beginning January 1, 2006, there will be a reduction in Treatment Authorization Request volume. This will impact staffing levels for EDS pharmacists and office staff, although staffing standards and the 24-hour turnaround time required by federal statute still must be maintained.

MM 12 (PC-71) X MMA 100-Day Prescription Supply

Medicare's Part D prescription drug plan began January 1, 2006. Part D ~~will assume~~ **assumes** responsibility for most of the prescription drugs for dually eligible beneficiaries. Currently, Medi-Cal allows a 100-day supply of most prescription drugs. Due to concern that Part D ~~may~~ **would** interrupt dual eligibles' prescription drug services or that currently prescribed drugs ~~will~~ **would** no longer be available, ~~it is expected that~~ Medi-Cal ~~will experience~~ **experienced** an increase in 100-day prescriptions during December 2005.

MEDI-CAL HOSPITAL/UNINSURED CARE DEMONSTRATION: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 0.1 (PC-140)	X		Medi-Cal Hospital/Uninsured Care Demonstration Waiver – Advanced GF Payments to DPH

Since December 2005, the Department has received requests for advances from nine of the 23 designated public hospitals (DPHs) that are experiencing severe cash flow problems stemming from prolonged negotiations between CMS, the DPHs and the Department over the funding and reimbursement protocol contained in the new Section 1115 Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD) Special Terms and Conditions.

In March 2006, the DPHs who submitted a request for an advance were given an interest-free interim cash relief payment from the GF, based on the provisions of Welfare and Institutions Code Section 14153. The advance to the DPHs will be repaid in June 2006, when the State is expected to be able to claim federal funding from California's Disproportionate Share Hospital allotment for payment of funds under the MH/UCD. The Health Care Deposit Fund will be credited with the federal funds claimed. These funds will then be transferred to the GF.

MH 0.2 (PC-144)	X	X	Medi-Cal Hospital/Uninsured Care Demonstration Waiver – DPH Rate Reconciliation

Under the MH/UCD, DPHs will no longer receive negotiated per diem payments comprised of GF and FFP. Instead, DPHs will receive estimated interim payments comprised of FFP only, based on the certification of public expenditures. However, the Department has continued to pay the DPHs the negotiated per diem payments pending the development of procedures for certifying public expenditures. The Department will begin payment of the new interim payments in April 2006, and all DPH claims for services beginning July 1, 2005 that had been paid the negotiated per diem payments will be reprocessed.

For hospitals whose new interim payment is higher than the negotiated per diem payment, the Department will reimburse the GF with FFP, and the hospitals will receive the additional FFP payment they are owed.

For hospitals whose new interim payment is lower than the negotiated per diem payment, the Department will claim the correct FFP based on the new interim payment and reimburse the GF. The remaining GF repayment that is owed by the DPHs will be reimbursed from the Physician and Non-Physician Payments when the State Plan Amendment is approved in FY 2006-07.

MEDI-CAL HOSPITAL/UNINSURED CARE DEMONSTRATION: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 0.3 (PC-141)	X	X	MH/UCD – CCS AND GHPP

Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the California Children Services (CCS) Program and Genetically Handicapped Persons Program (GHPP) from the Safety Net Care Pool funding established by the MH/UCD. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.

MEDI-CAL HOSPITAL/UNINSURED CARE DEMONSTRATION: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 1 (PC-55)	X	X	MH/UCD – DPH Interim Rates

Effective July 1, 2005, based on the Special Terms and Conditions of the ~~Medi-Cal Hospital/Uninsured Care Demonstration (~~MH/UCD~~)~~, payments for inpatient hospital costs for Medi-Cal beneficiaries will be as follows:

- Designated public hospitals (DPHs) will no longer receive negotiated per diem payments for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Designated public hospitals will now receive estimated, interim payments based on certified public expenditures (CPEs) for providing inpatient hospital care to Medi-Cal beneficiaries. The interim rate will be based on the hospitals' ~~audited Medicare~~ **filed Medi-Cal** 2552-96 cost reports, plus additional allowable costs, trended forward. The interim payment will include only the FFP. **A SPA was submitted in September 2005 and is currently pending approval by CMS.**

- Non-designated public hospitals (NDPHs) will continue to receive per diem payments based on rates negotiated by the California Medical Assistance Commission (CMAC), or based on costs, if the hospital does not participate in the Selective Provider Contracting Program (SPCP).

- Private hospitals will continue to receive per diem payments based on rates negotiated by CMAC, or based on costs, if the hospital does not participate in the SPCP.

MH 2 (PC-128)	X	X	MH/UCD – Inpatient Base Reduction

Effective July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, designated public hospitals will no longer receive negotiated per diem payments for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Designated public hospitals will now receive estimated, interim payments based on certified public expenditures for providing inpatient hospital care to Medi-Cal beneficiaries. The Medi-Cal base estimate will be reduced to reflect the negotiated per diem payments that are no longer made. Inpatient hospital costs for refugees, State only program eligibles, and non-emergency services to qualified aliens will not be reduced from the base.

MEDI-CAL HOSPITAL/UNINSURED CARE DEMONSTRATION: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 3 (PC-56)	X	X	MH/UCD – Safety Net Care Pool

Effective July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, a Safety Net Care Pool (SNCP) is established to support the provision of services to the uninsured. It creates the Health Care Support Fund which is to be comprised of federal funds that the Department claims based on CPEs. It is to be used first to meet the baseline funding authorized for designated public hospitals. Funds in excess of those needed for baseline funding are to be distributed according to the requirements specified in SB 1100 (Chapter 560, Statutes of 2005).

MEDI-CAL HOSPITAL/UNINSURED CARE DEMONSTRATION: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 4 (PC-51)	X	X	MH/UCD – DPH and NDPH DSH Payments

Effective July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the federal DSH allotment is only available for uncompensated Medi-Cal and uninsured costs incurred by designated and non-designated public hospitals. The non-federal share of costs is funded through State GF, **intergovernmental transfers (**IGTs) or CPEs. Non-emergency services for unqualified aliens are eligible for **DSH program** funding. **A SPA was submitted in September 2005 and was approved by CMS on May 5, 2006.**

Designated public hospitals will claim reimbursement from the DSH allotment for up to 100 percent of their uncompensated costs based on CPEs. These CPEs will constitute the non-federal share of costs. Under this new methodology, each designated public hospital will certify its uncompensated Medi-Cal and uninsured costs to the State. The State will submit claims for federal reimbursement based on the designated public hospitals' CPEs. The federal reimbursement ~~received~~ **that is matched to the CPEs** will be deposited in the newly established Demonstration DSH Fund.

Twenty of the ~~22~~ **23** designated public hospitals also may claim up to 175 percent of uncompensated costs. (~~Two~~ **Three** University of California hospitals are not eligible for 175 percent reimbursement.) Intergovernmental transfers from the government entity with which the designated public hospital is affiliated will constitute the non-federal share of these costs. These intergovernmental transfers will be deposited in the existing MIPA Fund and will be used to claim federal reimbursement. **The federal reimbursement that is matched to the IGTs will be in the Federal Trust Fund.**

Each designated public hospital will receive its allocation of ~~federal~~ DSH payments ~~either~~ from the Demonstration DSH Fund**,** ~~or through intergovernmental transfer-funded payments~~ **Federal Trust Fund, and MIPA Fund**.

Nondesignated public hospitals will claim reimbursement from the DSH allotment for up to 100 percent of their uncompensated Medi-Cal and uninsured costs using State General Fund as the non-federal share of costs. **The federal reimbursement that is matched to the GF will be in the Federal Trust Fund.**

The $85 million DSH administrative fee has been eliminated by SB 1100 for FY 2005-06 and any subsequent state fiscal years during the MH/UCD.

MEDI-CAL HOSPITAL/UNINSURED CARE DEMONSTRATION: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 5 (PC-58)	X	X	MH/UCD – Private Hospital DSH Replacement

Effective July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, private hospitals will no longer receive payments from the federal DSH allotment. The federal DSH allotment is now only available for designated and non-designated public hospitals.

Private hospitals will receive DSH replacement funds, the non-federal share of which is funded by the State General Fund. The payments provided by the Private DSH replacement funds will satisfy the State's payment obligations, if any, with respect to those hospitals under Federal DSH statute. The federal share of these payments will be regular Title XIX funding and will not be claimed from the federal DSH allotment.

MH 6 (PC-61)	X	X	MH/UCD – Private Hospital Supplemental Payment

Effective July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, supplemental reimbursement will be available to private hospitals. Private hospitals will receive payments from the newly established Private Hospital Supplemental Fund. SB 1100 requires the Department to transfer $118,400,000 annually from the General Fund to the Private Hospital Supplemental Fund to be used for the non-federal share of the supplemental payments. This funding will replace the amount of funding the private hospitals previously received under the Emergency Services Supplemental Payment (SB 1255/Voluntary Governmental Transfers (VGT)), Graduate Medical Education Supplemental Payment (Teaching Hospitals), and Small and Rural Hospital Supplemental Payment programs.

MH 7 (PC-92)	X	X	MH/UCD – Nondesignated Public Hospital Supplemental Payment

Effective July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, supplemental reimbursement will be available to nondesignated public hospitals. Nondesignated public hospitals will receive payments from the newly established Nondesignated Public Hospital Supplemental Fund. SB 1100 requires the Department to transfer $1,900,000 annually from the General Fund to the Nondesignated Public Hospital Supplemental Fund to be used for the non-federal share of the supplemental payments. This funding will replace the amount of funding the nondesignated public hospitals previously received under the Emergency Services Supplemental Payment (SB 1255/VGT) program.

MEDI-CAL HOSPITAL/UNINSURED CARE DEMONSTRATION: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
MH 8 (PC-66)	X	X	MH/UCD – Physician and Non-Physician Costs Effective July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, supplemental reimbursement based on CPEs will be available to designated public hospitals for their costs incurred for physician~~, intern, resident,~~ and non-physician practitioner services. The supplemental reimbursement under the MH/UCD is available only for costs provided to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. **A SPA was submitted in September 2005 and is currently pending approval by CMS.**
MH 9 (PC-74)	X	X	MH/UCD – Distressed Hospital Fund Effective July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, a Distressed Hospital Fund is established for hospitals that participate in the SPCP. SB 1100 requires the transfer of 20 percent per year over five years of the balance of the ESSP Fund (SB 1255/VGT) to the Distressed Hospital Fund. Contract hospitals that meet the following requirements, as determined by CMAC, are eligible for distressed funds: • The hospital serves a substantial volume of Medi-Cal patients. • The hospital is a critical component of the Medi-Cal program's health care delivery system. • The hospital is facing a significant financial hardship.
MH 10 (PC-100)	X	X	MH/UCD – Medically Indigent Adult Long-Term Care Program Effective July 1, 2005, based on the Special Terms and Conditions of the MH/UCD and SB 1100, the Department may claim federal reimbursement from the Safety Net Care Pool funding established by the MH/UCD for the currently State-only funded Medically Indigent Adult Long-Term Care program.
MH 11 (PC-101)	X	X	MH/UCD – Breast and Cervical Cancer Treatment Program Effective July 1, 2005, based on the Special Terms and Conditions of the MH/UCD and SB 1100, the Department may claim federal reimbursement from the Safety Net Care Pool funding established by the MH/UCD for currently State-only funded portion of the Breast and Cervical Cancer Treatment Program.

.

MANAGED CARE: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 0.1 (PC-146)		X	Restoration of Provider Payment Decrease

Due to the significant budget deficit projected for the FY 2003-04 fiscal year, Assembly Bill 1762, the Health Trailer Bill of 2003, required the Department to reduce provider payments, thereby requiring payments made to managed care health plans to be reduced by the actuarial equivalent amount of five percent on specific provider types. This resulted in approximately a two percent reduction to the capitation rates. The provider payment reduction will remain in effect until December 31, 2006. The payment restoration for all plans will be implemented on January 1, 2007.

M 0.2 (PC-150) X Capitation Rate Increases

The Department recently conducted a financial review of all Medi-Cal managed care plans to determine if any additional rate adjustments were needed to ensure that all plans would have sufficient resources to provide quality care to Medi-Cal beneficiaries. This review determined that rate increases for six plans will be needed to minimize the risk of insolvency and maintain compliance with required financial standards.

The additional funding for each plan will begin at the start of each plan's rate period, as follows:

Plan	Rate Increase Begins
Central Coast Alliance for Health	January 1, 2007
Health Plan of San Mateo	July 1, 2006
Partnership Health Plan	July 1, 2006
Santa Barbara Health Authority	January 1, 2007
Contra Costa Health Plan	October 1, 2006
Community Health Group	July 1, 2006

M 0.3 (PC-147) X X Two-Plan Model Default Algorithm

As a result of the implementation of the Auto Assignment Default Algorithm beginning December 2005, the Local Initiative plans are receiving a higher percentage of members who do not choose a plan within the prescribed amount of time. The increase is not only a result of changing to a performance-based algorithm, but also because the number of people assigned to Local Initiatives for Continuity of Care is no longer offset in assigning the remaining defaults. Commercial Plans typically have fewer people assigned because of Continuity of Care.

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 1 (PC-29)	X	X	Two-Plan Model [1]

Under the Two-Plan Model program, the Department contracts with two managed care plans in a county. One plan is a locally developed managed care health plan referred to as the Local Initiative (LI). The other plan is a non-governmentally operated Health Maintenance Organization referred to as the Commercial Plan (CP). (An exception exists in Fresno County where there are currently two Commercial Plans and no Local Initiative.) ~~Effective July 2004, Health Net replaced the previous CP, Blue Cross, in Kern County. Current contractors will continue to operate in all other counties.~~ Currently, twelve counties are fully operational under the Two-Plan Model.

The Two-Plan Model CP contracts for the Bay Area and Southern California counties ~~expired by~~ **were scheduled to expire** March 31, 2005. State and federal contract laws require contracts to be competitively bid through a procurement process. To comply with this requirement, a reprocurement ~~is currently in process~~ **was completed** for the CPs in the Bay Area (Alameda, Contra Costa, San Francisco, and Santa Clara) and ~~Southern California (~~Los Angeles, **and is still in process for** Riverside, and San Bernardino~~) counties~~ **Counties**. Due to a delay in the final contract award for the Bay Area/Southern California RFP, the CP contracts for the Bay Area and Southern California counties were amended to extend through March 31, 2006. ~~The CP contracts for the Southern California counties will be amended again to extend the term through June 30, 2006, or until the CP contractors from the RFP award begin operations. The amendments will allow for the termination of a plan in a specific county if a new CP contractor is awarded the contract from the reprocurement. The estimated start of operations for the Bay Area counties will be January 1, 2006, and for the Southern California counties July 1, 2006. There will be no budget impact when the RFP is awarded because the capitation rates will remain the same under a new contract term for either the incumbent or new contractor.~~ **The incumbents, Blue Cross of California Partnership Plan, Inc. (Blue Cross) and Health Net Community Solutions, Inc. (Health Net) were awarded the contracts for four Bay Area counties and Los Angeles county, respectively. Blue Cross and Health Net will continue operations in these counties for two years (effective 4/1/06, with the option for three 24-month extensions) per the RFP. The award contracts for Riverside and San Bernardino Counties is being rescored based on the RFP Hearing Officer's review of the appeal. Therefore, the Molina Healthcare of California Partner Plan Inc. (Molina) CP contract is being amended again to extend the term through March 31, 2007, or until the CP contractors from the RFP award begin operations. The amendments will allow for the termination of Molina in a specific county if a new CP contractor is awarded the contract from the procurement. There will be no budget impact when the RFP is awarded because the capitation**

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

rates will remain the same under a new contract term for either the incumbent or new contractor.

2005-06 capitation rates include:

- Rate adjustments for *Orthopaedic* increase.
- **Remainder of** rate adjustments for Nurse-to-Patient Staffing Ratio increases **for plans not receiving full amounts in existing rates**.
- Final BCCTP rates.

Funding adjustments for retroactive payments for prior periods have been included for the BCCTP, *Orthopaedic* increase, and the Nurse-to-Patient Staffing Ratio Increases.

[1] Stanislaus County converted back to a fully operational two-plan county in August 2005 (as described in PC-51).

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 2 (PC-30)	X	X	County Organized Health Systems

Five County Organized Health Systems (COHSs) are operational in eight counties. The **Partnership Health Plan of California (**PHC**)** ~~plan~~ includes undocumented alien beneficiaries (aid codes 55, 58, 5F, 5G, 5N).

COHS rate years for 2005-06 are as follows:

CalOPTIMA Orange County	10/1/05-9/30/06
Santa Barbara Regional Health Authority (SBRHA) Santa Barbara County	1/1/06-12/31/06
Health Plan of San Mateo (HPSM) San Mateo County	7/1/05-6/30/06
Partnership Health Plan of California (PHC) Solano County Napa County Yolo County	5/1/06-4/30/07
Central Coast Alliance for Health (CCAH) Santa Cruz County Monterey County	1/1/06-12/31/06

2005-06 capitation rates include:

- Rate adjustments for *Orthopaedic* increase.
- **The remainder of** rate adjustments for Nurse-to-Patient Staffing Ratio increases **(CalOPTIMA only)**.
- Final BCCTP rates.
- 3% COHS rate increase effective with each plan's 2004-05 rate period.
- ICF/DD Quality Assurance Fee for all plans (except HPSM) effective with each plan's 2004-05 rate period.

Funding adjustments for retroactive payments for prior periods (excluding Long Term Care) have been included for the ICF/DD Quality Assurance Fee, BCCTP, *Orthopaedic* increase, and the Nurse-To-Patient (NTP) Staffing Ratio Increase.

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 3 (PC-BA)	X	X	Average Monthly PHP Enrollment

Kaiser is the only remaining PHP and has contracts in Marin and Sonoma Counties. As of June 2005, the combined enrollment in Kaiser totaled 1,732 members.

FY 2005-06: 1,778 FY 2006-07: 1,855

Funding adjustments for retroactive payments have been included for the *Orthopaedic* increases, and the Nurse-To-Patient (NTP) Staffing Ratio increases.

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 4 (PC-37, 44)	X	X	AIDS Healthcare Foundation (AHF)

HIV/AIDS Managed Care Organization (MCO): Positive Healthcare Services (aka AIDS Healthcare Foundation or AHF) is located in Los Angeles, with an enrollment of 835 as of June 2005. Enrollment is expected to reach ~~875 by December 2005 and 900~~ **850** by June 2006 **and 875 by June 2007**.

Effective January 1, 2002, ADHC and drugs currently used to treat AIDS were included in the plan's contracted scope of service except the following:

Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) drugs classified as Nucleoside Analogs, Protease Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, approved by the federal Food and Drug Administration (FDA) after January 1, 2002 that receive a new Hierarchical Ingredient Code Listing/generic name.

This had no impact on the total budget as costs shifted from fee-for-service to managed care.

Savings Sharing/Incentive Distributions: Prior obligations exist for AHF. These are obligations that are owed to the contractors for cost savings created when actual costs are less than FFS equivalent costs. The process of making final determinations of the amount of savings sharing can extend beyond a two-year period. Because of the long period of time needed to make the final determinations, prior contracts have expired and/or encumbered funds have reverted before final payments can be made. Funds in FY 2005-06 and FY 2006-07 are needed to provide payments for prior years' savings sharing. Savings sharing is the state's terminology for what the federal government refers to as incentive arrangements. The methodology for calculating savings sharing/incentive distributions is the same.

AHF will expand into San Bernardino ~~in January 2006~~ and Riverside ~~County~~ **Counties** ~~March~~ **in October** 2006. ~~Projected enrollment~~ **Enrollment** for San Bernardino County is projected to reach ~~150 by June 2006 and~~ 270 by June 2007. ~~The projected enrollment~~ **Enrollment** in Riverside County is projected to reach ~~130 by June 2006 and~~ 250 by June 2007. The scope of services (SOS) will mirror the SOS for AHF in Los Angeles County. AHF will also participate in Savings Sharing for these programs.

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 5 (PC-31)	X	X	Geographic Managed Care [1]

Sacramento: Geographic Managed Care (GMC), as authorized by AB 336 (Chapter 95, Statutes of 1991), was implemented in Sacramento County as of April 1994. Contractors are: Health Net, Blue Cross, Kaiser, Western Health Advantage, Molina, and Care 1st. As of, June 2005, enrollment in GMC reached 172,396 members. A new contractor, Care 1st, became operational as of May 1, 2005.

San Diego: The plans participating in San Diego GMC are: Health Net, Blue Cross, Community Health Group, Kaiser, and Molina. As of June 2005, enrollment in San Diego GMC was 170,586. ~~Previous contractors Sharp and Universal terminated their contracts and their enrollment was assumed by Molina Healthcare effective June 1, 2005.~~ **Contracts with Sharp and Universal were acquired by Molina effective June 2005, with the enrollment assumed by Molina.** A new application process ~~is being~~ **was** conducted during the first half of FY 2005-06 with **other** new contracts ~~to be~~ awarded effective January 1, 2006. ~~It is expected that this application process will result in adding one additional (new) contractor in San Diego County~~. **A new contractor, Care 1st, became operational effective February 1, 2006.**

[1] 2005-06 capitation rates includes:

- Rate adjustments for *Orthopaedic* increase.
- Rate adjustments for Nurse-To-Patient Staffing Ratio increase.

Funding adjustments for retroactive payments for prior periods have been included for the BCCTP, *Orthopaedic* increase, and the Nurse-To-Patient (NTP) Staffing Ratio Increase.

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 6 (PC-39)	X	X	Stanislaus County Two-Plan Model Reconversion

In Stanislaus County, which was previously a converted county, the Commercial Plan (Omni) terminated its contract in October 1999. Fee-for-Service (FFS) was restored in Stanislaus as an option for beneficiaries pending the reprocurement of a Commercial Plan. ~~Currently, beneficiaries~~ ~~have~~ **Beneficiaries had** the option of choosing FFS or the Local Initiative. In the Spring of 2003, the Department released the Two-Plan Model, Central Valley Commercial Plan Request for Proposal.

HealthNet was awarded the contract to operate the commercial plan in Stanislaus County. HealthNet began operations in August 2005, and Stanislaus reverted back to a mandatory enrollment managed care county. However, six zip codes in the Turlock area will remain voluntary and beneficiaries will have the option to enroll into Blue Cross or FFS. Those beneficiaries who do not make a choice will be defaulted into Blue Cross, but will have the option to change back to FFS.

Effective June 2006, beneficiaries in the six voluntary zip codes will also have the option to enroll in HealthNet, in addition to the existing choices of the Local Initiative (Blue Cross) or FFS. Those beneficiaries who do not make a choice will remain in FFS with no defaults occurring.

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 7 (PC-34)	X	X	Senior Care Action Network

The Senior Care Action Network (SCAN) is a social health maintenance organization in designated areas of Los Angeles, San Bernardino, and Riverside Counties. This project provides medical, social, and case management services to Medicare beneficiaries ages 65 and over. Enrollees who are SNF or ICF certifiable are eligible for additional services. DHS contracts with SCAN for services to dually eligible members in the above counties. Dual eligible enrollment is expected to reach ~~4,600~~ **5,325** by June 30, 2006, and ~~5,800~~ **10,026** by June 30, 2007. SCAN is developing an outreach program targeting the dual eligibles in all service areas. Since beneficiaries would have greater benefits under SCAN than they would by enrolling in other health plans, enrollment is expected to increase in all counties and aid categories.

FY 2005-06 funding reflects a one-time lump-sum retroactive payment resulting from the inclusion of Orthopaedic Hospital ~~settlement money~~ **rate increases**. The payment covers the ~~excess~~ **additional** capitation due for FY 2001-02 through FY 2003-04. The rate adjustment has been fully incorporated into the rates effective October 1, 2004.

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 8 (PC-33)	X	X	PACE: Program of All-Inclusive Care for the Elderly

The Department contracts with four PACE organizations for risk-based capitated lifetime care of the frail elderly. PACE programs provide all medical services, home and community-based long-term care (including adult day health care) to Medi-Cal and Medi-Cal/Medicare crossover beneficiaries who are certified by DHS for skilled nursing facility or intermediate care facility level of care.

On Lok Senior Health Services started in November 1983. Projected enrollment of ~~898~~ **848 dual eligibles and 22 Medi-Cal only eligibles** is expected to be reached by June 30, 2006; and ~~933~~ **882 dual eligibles and 38 Medi-Cal only eligibles** by June 30, 2007, in San Francisco. In Alameda, projected enrollment of 74 **dual eligibles and 3 Medi-Cal only eligibles** is expected to be reached by June 30, 2006; and ~~94~~ **89 dual eligibles** and **4 Medi-Cal only eligibles** by June 30, 2007.

The Center for Elders Independence in Oakland started in July 1992. Expansion to an additional site in Berkeley was effective April 2000. Enrollment is expected to reach ~~430~~ **432 dual eligibles** and **44 Medi-Cal only eligibles** by June 30, 2006; and ~~470~~ **462 dual eligibles and 94 Medi-Cal only eligibles** by June 30, 2007.

Sutter Senior Care in Sacramento started in August 1992. Effective April 2000, one area of Yolo County is served through an existing Sacramento site. Enrollment is expected to reach ~~260~~ **250 dual eligibles and 3 Medi-Cal only eligibles** by June 30, 2006; and ~~290~~ **270 dual eligibles and 3 Medicare only eligibles** by June 30, 2007.

Alta Med Health Senior Buena Care in East Los Angeles started in January 1996. Enrollment is expected to reach ~~395~~ **296 dual eligibles and 79 Medi-Cal only eligibles** by June 30, 2006; and ~~450~~ **356 dual eligibles and 94 Medi-Cal only eligibles** by June 30, 2007.

FY 2005-06 funding reflects a one-time lump-sum retroactive payment resulting from the inclusion of *Orthopaedic Hospital* settlement money. The payment covers the excess capitation due for FY 2001-02 through FY 2003-04. The rate adjustment has been fully incorporated into the rates effective October 1, 2004.

FY 2005-06 funding reflects a one-time lump-sum retroactive payment resulting from rate adjustments that were paid to the plans beginning on October 1 of each year, but which were retroactively effective in each of those years. The retroactive adjustment reflects the number of months for each year the applicable rates were not paid.

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 9 (PC-40)	X	X	Risk Payments for Managed Care Plans

Medi-Cal managed care plans that have opted for reinsurance protections receive slightly lower capitation rates in return for financial risk limitations. Disbursements for risk/reinsurance expenditures occur when the cost of care in a 12-month period for a single beneficiary exceeds the amount specified in the health plan contract. Currently, Santa Barbara Regional Health Authority is the only managed care plan that has reinsurance protection. Estimated expenditures for risk provisions are $5,500,000 in FY 2005-06, and $6,000,000 in FY 2006-07.

M 10 (PC-42) X X Family Mosaic – Capitated Case Management Projects

Family Mosaic Project: Located in San Francisco, this program case manages emotionally disturbed children and adolescents at risk for out of home placement. Enrollment began in June 1993. Enrollment is expected to reach 144 as of June ~~2005~~ **2006**, and 165 by June ~~2006~~ **2007**.

M 11 (PC-OA) X X San Diego County Administrative Activities

The County of San Diego provides administrative services for the San Diego Geographic Managed Care program. These administrative activities include health care options presentations, explaining the enrollment and disenrollment process, customer assistance, and problem resolution. Federal funding for these activities was discontinued as of August 1, 2003. The County has absorbed the cost of the lost federal funding. The County of San Diego renewed its contract with the State effective July 1, 2005.

M 12 (PC-32) X X Quality Improvement ~~Assessment~~ Fee

The Budget Act and Health Trailer Bill of 2004 require managed care organizations with a contract under the Section 1903(m) of the Social Security Act to pay a Quality Improvement ~~Assessment~~ Fee. The plans will pay 6% of their total operating revenue to the General Fund. The increased cost for Medi-Cal eligibles will be covered by a 9.57% Medi-Cal rate increase, resulting in a 3% net revenue increase to the plans. **The rate increase for the Quality Improvement Fee was implemented for the Two-Plan Model in October 2005 effective July 2005.** ~~It is anticipated that~~ **The** rate increases associated with the quality improvement ~~assessment~~ fee ~~will be~~ **were** implemented ~~in October 2005~~ **February 2006,** retroactively effective to July 2005**, for the other plans**.

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
M 13 (PC-38)	X	X	Managed Care ~~Rate Increase Reimbursement~~ **Intergovernmental Transfer** The County of San Mateo will transfer funds **under an IGT** to the Department for the purpose of providing capitation rate increases to the Health Plan of San Mateo (HPSM), a COHS. These funds will be used for the nonfederal share of capitation rate increases paid to HPSM. The transfer of funds will begin in ~~January~~ **February** 2006 ~~and be~~ effective retroactively to July 2005.
M 14 (PC-36)	X	X	CalOPTIMA 3% Rate Increase The Budget Act of 2005 includes a 3% rate increase for CalOPTIMA, a County Organized Health System plan operating in Orange County in order to ensure the continuing fiscal viability of the plan. The 3% rate increase will be effective with the ~~next~~ rate period, which starts on October 1, 2005.
M 15 (PC-43)	X	X	Rate Increase for Community Health Group The Budget Act of 2005 includes a $3 million rate increase for Community Health Group, a Geographic Managed Care plan operating in San Diego County.
M 16 (PC-52)	X	X	SNF Rate Changes and Quality Assurance Fee Implementation of AB 1629 (Chapter 875, Statutes of 2004) will result in increases in capitation rates for managed care plans in FY 2005-06 and FY 2006-07 to account for cost increases for free standing skilled nursing facilities.
M 17 (PC-46)	X	X	FFS Costs for Managed Care Enrollees Managed care contracts specify that certain services are carved out of the rates paid for managed care enrollees. These services are provided through the fee-for-service system. The most significant carve-outs for most plans are federally qualified health care centers, rural health clinics, CCS services, and anti-psychotic drugs.
M 18 (PC-OA)		X	SPD Education and Outreach As part of the Governor's Budget proposal to target barriers to enrollment of seniors and persons with disabilities (SPDs) into managed care, the budget includes funding for the Department to enter into an interagency agreement **(IA)** for education and outreach activities to increase the voluntary enrollment of Medi-Cal SPDs in all managed care counties. **An IA with UC Berkeley is being negotiated to initiate education and outreach activities.**

OTHER: AUDITS AND LAWSUITS: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

			Applicable F/Y C/Y	B/Y	Change from Nov. Assumptions
A 1 (PC-95)	Lawsuits / Claims*				
a.	Attorney Fees of $5,000 or Less				
	1. *Sharp Coronado Hosp.*	03CS01431 & 04CS00157	$2,816		
	2. *Bontá v. Brenda Arnold, et al.*	TC 016584	1,340		
	3. *Trung Nguyen, et al.*	CV1484(H)POR	3,562		
	4.				
	Total		$7,718	$0	
	Fund Balance		$42,282	$50,000	
b.	Provider Settlements of $75,000 or Less				
	1. *Catholic Healthcare West, So. Calif.*	BC314469	$14,356		
	2. *Catholic Healthcare West, So. Calif.*	BC305351	43,770		
	3. *Catholic Healthcare West, So. Calif.*	BC310614	71,277		
	4. *Alta Bates Summit Medical Ctr.*	CGC-04-432045	31,357		
	5. *Catholic Healthcare West, So. Calif.*	BC322380	44,781		
	6. *Alta Bates Summit Medical Ctr.*	CGC-04-433296	15,662		
	7. *Catholic Healthcare West, So. Calif.*	BC322442	58,765		
	8. *Catholic Healthcare West, So. Calif.*	BC317348	63,671		
	9. *Memorial Hospital of Gardena*	BC319852	15,221		New
	10.*Greater SE Comm. Hosp.*	Adv Pro No. 04-10184	5,000		New
	11.*Good Samaritan Hosp*	BC329278	8,946		New
	12.*Cedars-Sinai Medical Ctr.*	BC324903	42,843		New
	13.*Catholic Healthcare West, So. Calif.*	BC322874	19,117		New
	14.*Columbia/HCA Western Group Inc.*	BC315224	68,238		New
	15.*Alta Bates Summi Medical Ctr.*	CGC-05-441571	63,170		New
	16.*Children's Hosp & Research Ctr*	CGC-05-440588	29,959		New
	17.*Daughters of Charity Health System*	BC336067	9,929		New
	18.*Daughters of Charity Health System*	BC330349	8,388		New
	19.*Daughters of Charity Health Sys*	CGC-05-437767	7,786		New
	20.*Pacific Alliance Medical Ctr, Inc*	*BC341191*	18,351		New
	21.*Alhambra Hospital Medical Ctr.et.al*	BC326245	75,696		New
	Total		$716,283	$0	
	Fund Balance		$883,717	$1,600,000	
c.	Beneficiary Settlements of $2,000 or Less				
	1.				
	2.				
	3.				
	Total		$0	$0	
	Fund Balance		$15,000	$15,000	
d.	Small Claims Court Judgments of $5,000 or Less				
	1. *Chapman Care Centre*	05WS01926	$592		
	2.				
	3.				

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

			Applicable F/Y C/Y	B/Y	Change from Nov. Assumptions
	Total		$592	$0	
	Fund Balance		$199,408	$200,000	
e.	Other Attorney Fees				
	1. *Calif. Advo. for Nursing Hm. Reform*	05-440183	$31,214		
	2. *Steven Moskowitz, et al.*	BS086446	321,674		
	3. *Jessica Gonzalez; et al.*	C 05 0214 CRB	14,668		
	4. *Frank O. Brown, M.D.*	05CS01153	15,291		
	5. *Emily Q. et al.*	CV 98 4181	860,738		New
	6. *Fitch v. Select Products Co.*	E028592	7,213		New
	7. *Kenya Day*	BS225046	1,856		New
	Total		$1,252,654	$0	
	f. Other Provider Settlements / Judgments				
	1. *Pacific Health Corp., et al.*	BC323608	$107,539		
	2. *Catholic Healthcare West*	CGC 04 433942	94,398		
	3. *Memorial Hospital of Gardena*	BC330376	102,137		New
	4. *St. Francis Medical Center*	C047027	1,742,632		New
	Total		$2,046,706	$0	
	g. Other Beneficiary Settlements				
	1.				
	2.				
	3.				
	Total		$0	$0	

* Amounts may exclude interest payments.

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
A 2 (PC-75)	X		Audit Settlements

Assume these audit settlements with the federal government will be executed in 2005-06:

(1) Deferral of claims for State mental health hospital patients aged 22 through 64 temporarily released to acute care hospitals during the period July 1, 1997 through February 28, 2001. Original amount to be repaid was $551,394. $283,990 has been repaid. Remaining amount to be paid is $267,404. Federal audit number CIN A-09-00055.

(1) Deferral of claims for services other than inpatient psychiatric care provided to Institutions for Mental Diseases (IMD) residents under age 21 in private psychiatric hospitals. Total of $155,000 to be repaid. Federal audit number A-09-02-00083.

(2) Deferral of claims for services other than inpatient psychiatric care provided to IMD residents under age 21 in State-operated psychiatric hospitals. Total of ~~$123,840~~ **$191,000** to be repaid. Federal audit number A-09-02-00084.

(3) Deferral of FFP for costs incurred by the State for individuals that had been determined ineligible by LA County for the period of January through April 2004, but whom the State's eligibility system continued to show as Medi-Cal eligible. The amounts of the deferrals are $17,582,379 (for 1st quarter of 2004) and $5,860,793 (for April 2004). The total is $23,443,172. The deferral numbers are CA/2004/2/E/09/MAP and CA/2004/3/E/13/MAP.

(4) Disallowance of the Refugee Medical Assistance/Entrant Medical Assistance Case Monitoring (RMA/EMA) funds expended for refugees beyond their time-eligibility. The total amount to be repaid is $63,147.

(5) **Deferral of claims for private mental health hospital patients aged 22 to 64 years temporarily released to acute care hospitals during the period of July 2003 through August 2005. Total of $1,919,000 to be repaid. Federal Audit CIN A-09-02-00061.**

A 3 (PC-96)	X	X	Notices of Dispute / Administrative Appeals – Settlements

Settlement agreements for disputes between the Department and the Two-Plan model managed care plans are estimated to be $1,000,000 for possible settlements in FY 2005-06 and $1,000,000 for FY 2006-07.

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
A 4 (PC-86)	X	X	Minor Consent Settlement

On June 17, 2002, the Department, Los Angeles County, and the U. S. Department of Justice executed a settlement agreement concerning an audit by the federal Office of the Inspector General relating to the incorrect claiming of FFP for services (especially mental health services) provided to minor consent eligibles from January 1, 1993, to the present. The terms of the settlement include payment of $73.3 million, plus interest, of which Los Angeles County paid $6.8 million within 10 days of receipt of the fully executed agreement. The balance of $66,500,000, plus interest, will be withheld from California's Medicaid payments over ten years, with the first "adjustment" to be made July 1, 2003. Additionally, the Department and Los Angeles County entered into a separate agreement dated June 14, 2002, in which the County agreed to reimburse the Department an additional $1,559,353. $59,353 was due on or before August 1, 2003, without interest. The remaining $1,500,000 was due in five installments of $300,000 commencing August 1, 2003, plus interest which commenced June 15, 2003. In August 2005, Los Angeles County paid the Department the entire $945,000 balance owed.

A 5 (PC-123)		X	Serono, S.A. and U.S. Affiliates Settlement

Serono Inc. and the California Attorney General reached a settlement as part of an agreement with the U.S. Department of Justice and Attorneys General from 42 other states. The agreement settled an investigation into the company's sales and pricing practices for its drug Serostim, which is used to treat AIDS-related wasting. The investigation focused on whether the company violated federal and state false claims acts or anti-kickback laws, which prohibit drug companies from offering incentives to doctors to prescribe a drug. These practices resulted in increased Medi-Cal reimbursements during 1997 to 2004 for unnecessary Serostim prescriptions.

A 6 (PC-119)	X		Cantwell Medical Pharmacy Audit Settlement

As a result of an Audits and Investigations Division audit for recovery, the Department will receive a reimbursement ~~of $18,553,000 ($9,276,000 GF)~~ from Cantwell Medical Pharmacy, Inc., in FY 2005-06. The audit finding related to improper billing for anti-hemophilia blood factor products.

OTHER: REIMBURSEMENTS: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 0.1 (PC-136)		X	Reimbursement of FFP for Non-Institutional Provider Overpayments

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 required that the federal government be reimbursed its share of all provider overpayments in the quarter in which the 60th day after discovery of an overpayment falls. Although the Department has done so for institutional overpayments, an internal auditor found that FFP was not being reported correctly for non-institutional provider overpayments. Changes in the Department's COBRA System to rectify the non-institutional reporting are being tested in FY 2005-06 and the system changes should be operational in FY 2006-07. At that time, the FFP will become due for all outstanding, non-institutional accounts receivable principal balances.

R 0.2 (PC-OA)	X	X	COHS Rebates Reconciliation

To increase drug rebate collections for the eight COHS counties, the Department will reconcile the counties' Paid Claims files with drug records obtained from the Pharmacy Benefits Manager (PBM) contractors who adjudicate the drug claims for COHSs to improve their drug data in order to improve drug rebate collections for these claims. The Department will enter into contracts to analyze edit reports, research cause and correction for critical data errors, establish error feed-back loops to the sources of the errors, develop corrective action plans, track error rates, and monitor improvement efforts. These ITSD efforts qualify for 75% FFP. The Department will submit a FSR for this project. Increased rebates are expected to begin in FY 2007-08.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 1 (PC-81) (PC-CA, OA)	X		Los Angeles County Medicaid Demonstration Project The original Los Angeles County Medicaid Demonstration Project (Project) expired June 30, 2000. An extension proposal was submitted to CMS to extend the project for an additional five years, from July 1, 2000, through June 30, 2005. CMS approved the Special Terms and Conditions for the extension of the waiver on January 17, 2001, and approved the SPA on January 22, 2001. The Special Terms and Conditions require a gradual phase-out of Waiver funding beginning FY 2002-03. In FY 2002-03 the Project FFP was reduced from $246,600,000 to $185,000,000. The FFP reduction continued in FY 2003-04 from $185,000,000 to $135,500,000 and in FY 2004-05 to $86,300,000. The waiver extension ended on June 30, 2005. Demonstration project close-out activities, including payment of claims and submission of the final project report, will continue in FY 2005-06 and FY 2006-07.
R 2 (PC-NA)	X	X	FMAP Changes The Federal Medical Assistance Percentage (FMAP), which determines the federal Medicaid sharing ratio for each state, was 50% for the Medi-Cal program effective for the federal fiscal year beginning October 1, 2002. Public Law 108-27, the federal Jobs and Growth Tax Relief Reconciliation Act of 2003, increased the FMAP to 54.35% from April 1, 2003, to September 30, 2003, and to 52.95% from October 1, 2003, to June 30, 2004. The FMAP will be 50.0% from July 1, 2004 to June 30, 2006. Beginning July 1, 2006, the FMAP is assumed to be 50.0%.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 3 (PC-54)	X	X	Dental Contract

The dental rates for the period August 2004 ~~to~~ **through** July 2005 are ~~estimated to be~~:

Refugees	All Others
$51.24	$9.22

The dental rates for the period August 2005 through July 2006 are:

Refugees	**All Others**
$34.99	**$8.52**

~~Rates which will be effective beginning July 2005 are currently under negotiation. In the interim, the current rate will be used.~~

The Budget Act and Health Trailer Bill of 2003 reduced selected provider payments by 5%, effective January 1, 2004. The Department had been temporarily enjoined from implementing this payment reduction for dental providers by federal court order. The Department won the appeal in August 2005. AB 1735 amended the implementation date from January 1, 2004, to January 1, 2006. The 5% payment reduction ~~expires~~ **would have expired** December 31, 2006**; however, SB 912 (Chapter 8, Statutes of 2006) rescinded the payment reduction effective March 4, 2006. Accordingly, the 5% payment reduction was factored into the new dental rates for the period January 1 through March 3, 2006.** ~~The savings from the dental payment reduction has been included in the Provider 5% Payment Decrease policy change.~~

Full operations for the previous dental FI contract ended April 30, 2005. The new dental FI contract became effective May 2005.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 4 (PC-35)	X	X	Dental Geographic Managed Care

The Geographic Managed Care (GMC) project in Sacramento County covers dental services for eligibles with mandatory aid codes and SSI/SSP on a voluntary basis. Since April 1994, dental managed care services to beneficiaries have been delivered through four contractors. Currently, there are approximately **169,000** ~~168,000~~ beneficiaries. Implementation of this program has also increased access to specialist care for beneficiaries. In addition, contractors are required to reimburse DHS for all administrative and regulatory contract monitoring costs, including equipment, staff salaries and related expenses.

~~Current dental managed care rates were updated to include rate reductions including a 5% actuarial equivalent to the fee-for-service decrease for services that was included in The Budget Act and Health Trailer Bill of 2003. The reductions were effective January 1, 2004 and are ongoing.~~

Procurement for the program has been completed. The four current GMC contracts will expire December 31, 2007.

R 5 (PC-35)	X	X	Dental Managed Care within Medi-Cal Two-Plan Model Counties

The 1997-98 Budget Act made provision for the Department to enter into contracts with health care plans that provide comprehensive dental benefits to Medi-Cal beneficiaries on an at risk basis. Additionally, the Budget Act allowed the Department to require that dental managed care contractors reimburse the Department for all administrative and regulatory contract monitoring costs, including equipment, staff salaries and related expenses.

~~The Budget Act and Health Trailer Bill of 2003 included a decrease in managed care rates. This decrease is related to those services in Medi-Cal fee-for-service that are receiving a rate reduction. The rate decrease, an actuarial equivalent of the 5% fee-for-service decrease for those specified services, was effective January 2004.~~

The Department ~~is currently contracting~~ **has contracted** with ~~six~~ **eight** dental plans that are providing services as voluntary prepaid health plans in Los Angeles County. These contracts will expire June 30, 2007.

R 6 (PC-116)	X	X	EDS Cost Containment Projects – Program Savings

The Department has approved implementation of proposals developed by the Fiscal Intermediary (EDS) to contain Medi-Cal costs. The cost containment proposals result in savings to the Medi-Cal program. The Fiscal Intermediary will share in the achieved savings for two years after implementation of each proposal.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 7 (PC-OA)	X	X	MIS/DSS Contract

The Management Information System and Decision Support System (MIS/DSS) gathers data from provider, financial, eligibility and managed care/fee-for-service encounter and claims data into an integrated, knowledge-based system that is used by staff in various DHS units, including the Audits and Investigations Division in its anti-fraud efforts. A Non-Competitive Bid Contract Extension with MEDSTAT was approved and is effective April 16, 2004 through April 16, 2006 in order for the Department to continue access to the MIS/DSS database and perform data feeds during a rebid for services.

MIS/DSS contract costs will continue through the current and budget years. A new contract for four years, with three one-year extensions, will be awarded to the winning vendor of the competitive bid procurement. The new MIS/DSS contract is expected to be awarded in ~~May~~ **June** 2006. In order to provide continuous access to the system during the procurement process, CDHS is requesting a non-competitive bid extension of nine months for the MEDSTAT contract. The extension would expire in January 2007.

R 8 (PC-105)	X	X	Indian Health Services

Effective April 21, 1998, Medi-Cal implemented the Indian Health Services (IHS) memorandum of agreement (MOA) between the federal IHS and CMS. The agreement provided that California can be reimbursed 100% federal medical assistance percentage for payments made by the State for services rendered to Native Americans through IHS tribal facilities. ~~Thirty-one~~ **Forty-four** clinics in California have elected to participate under the IHS/MOA. Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

R 9 (PC-OA)	X	X	Baby Welcome Kits

Beginning in November 2001, Title XIX FFP has been claimed for the "Welcome Kits" distributed by the California Children and Families Commission (Proposition 10) to parents of Medi-Cal eligible newborns.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 10 (PC-59)	X		DSH Payments

SBs 855 and 146 (Chapters 279 and 1046, Statutes of 1991) established the Medi-Cal Inpatient Payment Adjustment (MIPA) Fund, which provides for supplemental payments to disproportionate share hospitals (DSH). Public entities were mandated to make intergovernmental transfers to the fund. Of the annual transfers, $85 million was transferred to the Medi-Cal local assistance item of the Budget Act in FY 2003-04. The Health Trailer Bill of 2002 (AB 442, Chapter 1161, Statutes of 2002) established the transfer amount at $85 million in FY 2003-04 and each fiscal year thereafter.

Title 42 USC 1396r-4 established the maximum federal DSH allotment amounts for SFY 1997-98 through SFY 2001-02. HR 5661 amended Title 42 USC 1396r-4 by adding Special Rule for Fiscal Years 2001 and 2002 as Subsection (4) to Section (g), Limitations on Federal Financial Participation. Subsection (4) allowed the maximum federal DSH allotment amounts for SFY 2000-01 and 2001-02 to change from the prior year actual allotment amount by the change in the annual consumer price index (CPI). After the Special Rule of Subsection (4) expired in SFY 2002-03, the maximum federal allotment was $899,802,000, established by the SFY 2001-02 table amount adjusted by the change in the annual CPI. This created a significant decrease in the maximum federal allotment between SFY 2001-02 and SFY 2002-03. HR 5661 established that, beyond SFY 2002-03, the maximum federal allotment is determined by the prior year actual allotment amount adjusted by the change in the annual CPI.

HR1, the Medicare Prescription Drug Act, increased the DSH allotment by 16 percent in SFY 2003-04. This one-time increase fixed the federal DSH allotment at $1,032,579,800 until the annual allotment computed by the HR 5661 methodology (adjusting the prior year funding level by the CPI) exceeds $1,032,579,800. At that time, the HR 5661 methodology will apply.

The remaining FY 2003-04 and FY 2004-05 payments will be paid in FY 2005-06. Please refer to Assumptions MH 0.4 and MH 0.5 for a description of the new funding methodology under the MH/UCD.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 11 (PC-88)	X		Voluntary Governmental Transfers

Section 14085.6 of the Welfare and Institutions Code established the Emergency Services and Supplemental Payments (ESSP) Fund. Voluntary contributions to the fund from public entities, which qualify for FFP, were used by CMAC to make supplemental payments to select disproportionate share hospitals contracting with the State of California under the Selective Provider Contracting Program (SPCP) for the provision of necessary acute inpatient hospital services to Medi-Cal recipients.

The remaining FY 2004-05 payments will be paid in FY 2005-06. Effective July 1, 2005, the MH/UCD will replace the funding received under the Voluntary Governmental Transfer. SB 1100 requires the transfer of 20 percent per year of the balance of the ESSP Fund to the Distressed Hospital Fund. Please refer to Assumptions MH 0.6 and MH 0.7 for a description of the new funding methodology.

R 12 (PC-62) X X Capital Project Debt Reimbursement

SB 2665 (Chapter 1310, Statutes of 1990), and SB 1732 (Chapter 1635, Statutes of 1988) authorize Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. To qualify, a hospital must be a disproportionate share hospital, must have either a SPCP or County Organized Health Systems contract with the State of California, and must meet other specific hospital and project conditions specified in Section 14085.5 of the Welfare and Institutions Code.

R 13 (PC-60) X X Developmental Centers/State Operated Small Facilities

The Medi-Cal budget includes the estimated federal fund cost of the **California** Department of Developmental Services' (CDDS) Developmental Centers (DCs) and two State-operated small facilities.

R 14 (PC-OA) X X **C**DDS Administrative Costs

The Medi-Cal budget includes FFP for **C**DDS Medi-Cal-related administrative costs. Beginning in FY 2001-02, **C**DDS began budgeting the General Fund in its own departmental budget.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 15 (PC-50) (PC-OA)	X	X	Mental Health Services – CDMH The Medi-Cal budget includes the estimated cost of specialty mental health services provided to Medi-Cal beneficiaries through ~~two~~ **the** Medi-Cal ~~managed care~~ **Specialty Mental Health Services** waiver ~~programs~~ **program** administered by CDMH. On April 26, 2005, CMS approved the renewal of the Specialty Mental Health Waiver for the term April 1, 2005 through March 31, 2007. This approval included merging the Medi-Cal Mental Health Care Field Test (San Mateo County) and Solano County Mental Health programs into the Specialty Mental Health Waiver program, effective July 1, 2005. Beginning in FY 2006-07, the GF cost of EPSDT mental health services and the San Mateo Pharmacy/Lab contract will be included in the CDMH budget rather than in the CDHS budget.
R 16 (PC-81)	X	X	Healthy Families – CDMH Title XXI FFP will be claimed for the cost of providing additional mental health services to Severely Emotionally Disturbed children who have exhausted Healthy Families mental health benefits.
R 17 (PC-76)	X	X	State Hospitals – CDMH Beginning with the November 2002 Estimate for FY 2002-03, the California Department of Mental Health (CDMH) began budgeting for its own Medi-Cal related state hospital reimbursements. Previously, these reimbursements had been budgeted by the California Department of Developmental Services on behalf of CDMH.
R 18 (PC-68) (PC-OA)	X	X	Short-Doyle/Drug Medi-Cal – CDADP Title XIX FFP will be claimed for Drug Medi-Cal services administered by the California Department of Alcohol and Drug Programs (CDADP).
R 19 (PC-OA)	X	X	Perinatal HIV Testing Project The Perinatal HIV Testing Project, administered by the Office of AIDS, develops and disseminates HIV educational material for prenatal women, and provides prenatal HIV testing information to perinatal care providers and organizations. Technical assistance and training is offered to those prenatal providers who currently treat Medicaid patients. Beginning in 1998, CMS approved an expansion into outreach to individuals in addition to providers.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 20 (PC-20) (PC-OA)	X	X	CLPP Case Management Services The Childhood Lead Poisoning Prevention (CLPP) Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments, which provide case management services. To the extent that local governments provide case management to Medi-Cal eligibles, federal matching funds can be claimed.
R 21 (PC-103)	X	X	Cigarette and Tobacco Products Surtax Funds Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds have been allocated to aid in the funding of the *Orthopaedic Hospital* settlement for FY 2005-06. The Hospital Services Account will contribute $5,823,000 and the Unallocated Account will contribute $20,008,000. In FY 2006-07, it is estimated that the Hospital Services Account will contribute $18,000,000 and the Unallocated Account will contribute ~~$25,500,000~~ **$18,784,000**.
R 22 (PC-72)	X	X	Certification Payments for DP-NFs In the Budget Act of 2001, the Legislature took action to allow Nursing Facilities (NF) that are Distinct Parts (DP) of acute care hospitals to claim FFP on the difference between their projected costs and the maximum DP-NF rate Medi-Cal currently pays. The acute care hospitals must be owned and operated by a public entity, such as a city, county, or health care district. The Department froze the median rate and the "projected cost per patient per day" in FY 2004-05. In February 2005, the Department determined that the "projected cost per patient per day" should not have been frozen. Facilities below the median, with a difference between their frozen Medi-Cal rate and their allowable projected cost, met the requirements for certification payments for the rate year 2004-05. These funds are expected to be paid to the facilities in FY 2005-06. Other DP-NFs inadvertently overstated their Medi-Cal days and owe FFP dollars on these days. These funds are expected to be paid to the State in FY 05-06.
R 23 (PC-BA)	X	X	Alternative Birthing Centers Pursuant to Welfare and Institutions Code Section 14148.8, the Department is required to provide Medi-Cal reimbursement to alternative birthing centers (ABCs) for facility-related costs at a statewide all-inclusive rate per delivery. This reimbursement must not exceed 80% of the average Medi-Cal reimbursement received by general acute care hospitals with Medi-Cal contracts. The reimbursement rates must be updated annually and must be based on an average hospital length of stay of 1.7 days. The ABC rates will increase each year by the same percentage as the CMAC average acute care hospital contract rate.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 24 (PC-OA)	X	X	Health and Human Services Agency HIPAA Funding

In order to meet the requirements of HIPAA and ensure that its provisions are applied uniformly in the impacted programs, a HIPAA office has been established at the Health and Human Services Agency. Title XIX federal financial participation is available for HIPAA activities related to Medi-Cal.

R 25 (PC-78) X X Hospice Rate Increases

Pursuant to state regulations, Medicaid hospice rates are established in accordance with 1902(a)(13), (42 USC 1396a(a)(13)) of the federal Social Security Act. This act requires annual increases in payment rates for hospice care services based on corresponding Medicare rates. New hospice rates are effective October 1st of each year.

Effective February 1, 2003, hospice room and board providers are reimbursed at 95% of the Medi-Cal per-diem rate paid to the facility with which the hospice is affiliated. This change in reimbursement methodology was made to reflect the CMS allowable rate, in accordance with 42 USC 1396a(a)(13)(B) and 1902(9a)(13)(B) of the federal Social Security Act.

R 26 (PC-80) X X Annual MEI Increase for FQHCs and RHCs

The Department implemented the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) included in the 2000 Benefits Improvement and Protection Act on January 1, 2001. Clinics have been given the choice of a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate, or (2) their 2000 cost-based rate. Whichever PPS rate the clinic has chosen will receive an annual rate adjustment. The annual rate adjustment is the percentage increase in the Medicare Economic Index (MEI) **and is effective October 1st of each year**. The MEI increase effective October 1, 2005 is 3.1 percent. The MEI increase effective October 1, 2006, will be 2.8 percent.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 27 (PC-90)	X	X	Nurse-to-Patient Ratios for General Acute Care Hospitals

AB 394 (Chapter 945, Statutes of 1999) requires the Department to adopt regulations establishing minimum, specific and numerical licensed nurse-to-patient ratios by licensed nurse classification and hospital unit for general acute care and psychiatric hospitals. The regulations specify the number of patients that may be assigned per licensed nurse in the following hospital units: critical care, burn unit, labor and delivery, surgical service, perinatal service, pediatric service, postanesthesia recovery unit, emergency service, step-down/intermediate care unit, telemetry unit, medical/surgical care unit, specialty care unit, and psychiatric unit. The regulations were implemented January 1, 2004. On January 1, 2005, the nurse-to-patient ratio for medical, surgical, and combined medical/surgical units, and mixed units were scheduled to further change from 1:6 to 1:5. The Department filed emergency regulations to defer this change until January 1, 2008. However, a court injunction has prohibited implementation of the emergency regulations.

R 28 (PC-67)	X	X	Hospital Outpatient Supplemental Payments

AB 915 (Chapter 747, Statutes of 2002) creates a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. The supplemental amount, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal match used to draw down FFP will be paid exclusively with funds from the participating facilities and will not involve General Fund dollars. Retroactive claiming will be allowed to July 1, 2002. ~~Payments were made in September 2004 for FY 2002-2003. Payments were made in June 2005 for FY 2003-2004.~~ Payments are expected to be made in June 2006 for FY 2004-05, and in June 2007 for FY 2005-06.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 29 (PC-107) (PC-113)	X	X	Inpatient Psychiatric Care for Residents of IMD Facilities The Department will establish claims processing controls to prevent FFP from being claimed for inpatient psychiatric claims for 21 to 64 year old residents of private and county-operated psychiatric hospitals that are Institutions for Mental Diseases (IMDs). These costs will be paid with State General Fund money only. An audit (#A-09-02-00061) conducted by the federal Office of the Inspector General (OIG) for the period July 1, 1997, to January 31, 2001, concluded that FFP was being incorrectly claimed for these residents. (See Audit Settlements Assumption.) The Department will identify and refund unallowable FFP claimed for the period prior to the audit (July 1, 1987, through June 30, 1997) and after the audit (February 1, 2001 to date). Because of system changes implemented at the end of August 2005, CDHS will no longer pay inpatient claims for this population, as of September 2005. This will result in a savings to CDHS of approximately $1,771,000 GF annually, beginning in September 2005. In addition, Federal audits A-09-02-00083 (private psychiatric hospitals) and A-09-02-00084 (State-operated psychiatric hospitals) concluded that FFP was incorrectly claimed for services other than inpatient psychiatric care provided to IMD residents under age 21 during the period July 1, 1997 through January 31, 2001. ~~The Department will identify and refund unallowable FFP claimed for the period after the audits (February 1, 2001 and ongoing).~~
R 30 (PC-70)	X	X	FFP For Local Trauma Centers The Budget Act of 2003 provided funding for Los Angeles County and Alameda County to transfer funds to the Medi-Cal program to be matched with federal funds. The combined funds will be used to offset costs of care at local trauma care centers throughout the counties.
R 31 (PC-130)	X	X	Federal Drug Rebate Program Federal law requires drug manufacturers to provide rebates to the federal government and the states as a condition of FFP in the states' coverage of manufacturers' drug products. The manufacturers have 30 days to make payment after being billed. **In 2005, AIDS Healthcare Foundation and the Health Plan of San Mateo were found to meet the criteria of a Managed Care Organization and can no longer participate in the federal Medicaid drug rebate program.**

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 32 (PC-129)	X	X	State Supplemental Drug Rebates

The Department negotiates state supplemental drug rebates with drug manufacturers to provide additional drug rebates over and above the federal rebate levels. As with the federal drug rebates, the Department estimates the state supplemental rebate amounts by using actual fee-for-service trend data for drug expenditures and applying a historical percentage of actual amounts collected to the trend projection.

R 33 (PC-104)	X	X	Non FFP Drugs

Federal Medicaid rules specify that there is no FFP for drugs provided by state Medicaid Programs if the manufacturer of the drug has not signed a rebate contract with CMS. The Department is establishing claiming procedures to ensure that FFP is claimed correctly.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 34			Drug Budget Reduction
			The Health Trailer Bill of 2002 includes the following Medi-Cal drug budget reductions:
(PC-111)	X	X	**A**~~C~~. Enteral Nutrition Contracts
			Medi-Cal currently covers nutritional products for individuals who are unable to eat regular food to sustain their health. Many of the products are expensive and the Department is seeking ways to reduce the overall cost of providing the enteral nutrition products. The Department implemented a provider rate reduction and began the process of contracting with nutritional product manufacturers for lower costs or rebates. The process began in 2002 and ~~has been~~ **was** delayed due to legal issues regarding the contract content. With these issues resolved, the ~~Department will have its~~ **Department's** first contracts **were** in place ~~by~~ **on** January **1,** 2006**, with provider payment reductions effective March 1, 2006**. June 2007 is the target date to have all products under contract.
(PC-FI)	X	X	**B**~~I~~. Maximum Allowable Ingredient Cost, Generic Drugs Changes the pricing methodology for the Maximum Allowable Ingredient Cost (MAIC) for generic drugs from AWP – 5% to the Wholesale Selling Price (WSP). The WSP represents the actual price at which the wholesaler sells the drug product to pharmacies. The implementation timeline has been extended due to the complexity of the data gathering to establish systems within each of more than twenty California pharmaceutical wholesalers. Estimated implementation of the new MAIC values is July 2007. **Generic drug contracting has been incorporated into this assumption.**
			The drug budget reductions required changes to the FI-operated drug reimbursement systems and the addition of a pharmacist position to the FI. Several of the changes have been implemented.
R 35			Medical Supply Reductions
			The Health Trailer Bill of 2002 (AB 442, Chapter 1161, Statutes of 2002) includes the following medical supply reimbursement revisions:
(PC-114)	X	X	A. Medical Supply Contracting & Maximum Allowable Product Cost (MAPC) for Medical Supplies
			Allows contracting with medical supply manufacturers and changes the reimbursement methodology for establishing the MAPC for medical supplies from AWP to WSP.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 36 (PC-122)	X	X	New Therapeutic Category Reviews

The Department has added additional staff positions to perform new annual drug therapeutic category reviews (TCRs). Drugs are organized into therapeutic categories, such as antibiotics, or drug that treat hypertension, acid reflux, etc. There are many as 114 of these therapeutic categories. The Department regularly conducts TCRs on these drugs to determine safety, efficacy, essential need, potential of misuse, and cost, prior to including drugs in the List of Contract Drugs. Drugs on the List do not require prior authorization prior to dispensing. The first ~~new~~ TCRs will be for:

- Statin drugs for hypercholesterolemia (Implementation Date 7/2004)
- Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARB) (cardiac drugs) (Impl. Date 7/2004)
- Non-sedating antihistamines (Impl. Date 8/2004)
- Antidepressants, oral (Impl. Date 7/2004)
- Proton pump inhibitors (Impl. Date 1/2005)
- Papain/urea and papain/urea/cholorhyllin debriding products (Impl. Date 9/2005)

The Department is awaiting the changes in drug utilization from the impact of Medicare Part D before determining the appropriate new TCRs to pursue.

R 37 (PC-OA)	X	X	EPSDT Case Management

Medi-Cal provides funding for the county administration of the CHDP Program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions. As more children shift from CHDP to the CHDP Gateway, costs for county administration shift from the state funded CHDP Program to the Medi-Cal and Healthy Families programs.

R 38 (PC-OA)	X	X	CCS Case Management Costs

Medi-Cal provides funding for the county administration of the California Children's Services (CCS) Program for those children that receive CCS services that are Medi-Cal eligible.

R 39 (PC-106)	X	X	State Only IMD Ancillary Services – **C**DMH

Effective July 1, 1999, the cost of ancillary services for Medi-Cal eligibles who have not attained 65 years of age and who are residents of **C**DMH Institutions for Mental Diseases (IMDs) is entirely state-funded.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 40 (PC-118)	X	X	Aged Drug Rebate Resolution

The Budget Act of 2003 includes funding for staff to resolve aged drug rebate payment disputes. Between 1991 and 2002 the Medi-Cal program accumulated large rebate disputes with participating drug companies. **An Office of Inspector General (OIG) audit identified $29.5 million as being aged drug rebate payment disputes**. An approved Budget Change Proposal (BCP) added four permanent staff in FY 2002-03 to recover additional rebate amounts from these aged disputes.

An approved BCP added 11 temporary staff in FY 2003-04 to allow the Department to resolve all aged disputes during FY 2004-05. **This estimate assumes the staff will continue in FY 2006-07.**

R 41 (PC-117) X X Non-Contract Hospital Audits

The Department's Audits and Investigations Division audits/reviews 100% of the acute care hospital cost reports filed each year. Due to limited staffing, a number of cost reports filed by non-contract hospitals are reduced to desk audits/reviews and do not receive a full scope field audit. In addition, the majority of home offices related to these hospitals do not receive field or desk audits due to limited staffing. Non-contract hospitals are hospitals that provide care to Medi-Cal beneficiaries but do not have contracts with the California Medical Assistance Commission (CMAC). During the performance of a field audit/review, procedures are performed to test the validity and accuracy of the hospital's allowable costs and billings more extensively than during a limited desk audit. The Department expects to realize additional savings by adding 20 positions to increase the number of field audits/reviews performed on non-contract hospitals and related home offices. Savings began in April 2005.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 42 (PC-73)	X	X	FQHC Rate Adjustments

The Benefits Improvement and Protection Act of 2000 (BIPA 2000) allows federally qualified health centers (FQHCs) and rural health clinics (RHCs) to receive increases to their prospective payment system (PPS) rates as a result of scope of service changes for new services that FQHCs/RHCs add subsequent to the establishment of their initial PPS rates.

The Department has developed and implemented the methodology to calculate scope of service changes. The methodology was implemented during the 2004-05 Fiscal Year. These scope of service increases are being applied retroactively to January 1, 2001.

In addition, the Department is retroactively reimbursing FQHCs/RHCs for required rate differential payments for Medicare crossover and managed care beneficiaries and beneficiaries receiving CHDP/EPSDT screens.

There are also lost savings associated with the cessation of cost-based FQHC audits. The Department ceases to perform these audits once a provider switches to PPS reimbursement.

R 43 (PC-OA)	X	X	Postage and Printing – Third Party Liability

The Third Party Liability Branch uses direct mail and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and insure that Medi-Cal is the payor of last resort. The number of forms/questionnaires printed and mailed and report information received correlates to the Medi-Cal caseload.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 44 (PC-OA)	X	X	Continuous Nursing Care Pilot Project

AB 359 (Chapter 845, Statutes of 1999) required the Department to establish a Section 1915(b) waiver pilot program to provide continuous 24-hour nursing care to developmentally disabled individuals in the least restrictive setting. ~~The Department submitted a renewal application to CMS in June 2005, with a request for an~~ **On September 23, 2005, CMS approved the waiver renewal application for an additional two years,** effective ~~date of~~ October 1, 2005 through September 30, 2007. The Department submitted the independent assessment required for the renewal in July 2005 upon receipt from the Department of Finance. The Department is budgeting $250,000 in FY 2006-07 for a final independent assessment to determine the feasibility and cost effectiveness of establishing the Intermediate Care Facility for the Developmentally Disabled-Continuous Nursing **(ICF/DD-CN)** as a permanent new provider type.

The ICF/DD-CN daily rates are based on the ICF/DD-N daily rates, including the Pediatric Sub-Acute Ventilator rates. The Department has discovered that the ICF/DD-CN daily rates have not been adjusted for the annual ICF/DD-N rate changes. The Department will recalculate the daily rates to include these adjustments that were inadvertently omitted for FY 2001-02 through FY 2005-06.

R 45 (PC-OA)	X	X	TAR Postage

Postage costs related to mailing treatment authorization request-related documents to providers and beneficiaries are budgeted in local assistance.

R 46 (PC-91)	X	X	HIPP Premium Payouts

The Department pays the premium cost of private health insurance for high-risk beneficiaries under the Health Insurance Premium Payment (HIPP) program when payment of such premiums is cost effective.

R 47 (PC-87)	X		Medicare HMO Premiums

Beginning January 1, 2001, Medi-Cal began paying a monthly premium to Health Maintenance Organizations that have enrolled beneficiaries eligible for both the Medi-Cal and Medicare programs (dual eligibles). Premium payments are made to ensure that dual eligible beneficiaries will remain enrolled in these plans and that Medi-Cal will avoid paying the pharmacy costs for these individuals. During 2005, the Department determined that, because of the implementation of the Medicare Part D drug benefit, it will no longer be cost effective to pay these premiums after Part D begins on January 1, 2006. Therefore, the Department will no longer pay for these premiums after December 2005.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 48 (PC-49)	X	X	Medicare Part A and Part B Buy-In

The Department pays CMS for Medicare Part A (inpatient services) and Part B (medical services) premiums for those Medi-Cal beneficiaries who are also eligible for Medicare.

These premiums allow Medi-Cal beneficiaries to be covered by Medicare for their cost of services, thus saving Medi-Cal these expenditures. The premium amounts are set by CMS effective January 1st of each year. Beginning January 1, 2005, premiums are $375 for Part A and $78.20 for Part B. Beginning January 1, 2006, premiums are $410 and $88.50, respectively. Premiums are estimated to be $448 and $100.20, respectively, beginning January 1, 2007.

Beginning in January 2004, some Medicare HMOs decided to implement the BIPA 606 rule. This rule allows the Medicare HMOs to refund a portion of the Medicare Part B premium to eligible Medicare beneficiaries. Since California currently pays these Medicare Part B premiums on behalf of the Medicare/Medi-Cal beneficiaries, California receives these refunds. These refunds are shown as an adjustment to the Medicare Part B monthly invoice. There are approximately 12,000 beneficiary records that receive this adjustment. The adjustment is either $10 or $15 per beneficiary per month, depending on the Medicare HMO.

R 49 (PC-17)	X	X	Medicare Part B Deductible Increases

MMA increased annual Medicare Part B deductibles by $10 (for a total of $110) on January 1, 2005, with additional increases based on inflation every year thereafter. Each subsequent year, **on January 1,** the deductible will be increased by the percent increase in Medicare per capita costs. The deductible will increase by $14 on January 1, 2006, and is estimated to increase by an additional $14 on January 1, 2007.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 50 (PC-84)	X	X	Non-Contract Hospital 10% Interim Rate Reduction

The Trailer Bill of 2004 reduced non-contract hospital interim payments for acute inpatient services provided during FY 2004-05 by 10% effective September 1, 2004. The 10% reduction will be applied to the interim rate on file and in effect on January 1, 2004. The interim payment provides payment for services provided through the non-contract hospital's fiscal year.

Subsequent to the receipt of a non-contract hospital's Medi-Cal cost report for FY 2004-05, a cost settlement is performed by the Department. This cost settlement includes an audit to determine allowable and reimbursable costs related to the care provided to Medi-Cal patients. The cost settlement also includes a reconciliation of amounts paid (interim payments) versus amounts payable. Normally, if audited costs are lower than those reported in the cost report, the hospitals reimburse the difference to Medi-Cal. If audited costs are higher, Medi-Cal reimburses the difference to the hospitals. The final reimbursable costs computed for FY 2004-05 will be limited to the lesser of the FY 2004-05 audited Medi-Cal reimbursable costs or the as-audited reimbursable costs computed using the average cost per day for the hospitals' FY End in 2003 and the number of Medi-Cal days for FY 2004-05. The final cost determinations will be made beginning in FY 2006-07.

R 51 (PC-97)	X	X	Out-of-State Hospital Judgment

Out-of-state hospitals have been reimbursed for acute care inpatient services at the lesser of the hospital's actual billed charges or the most recent statewide average of the rates paid to all California hospitals, as reported by the California Medical Assistance Commission (CMAC) in its annual report to the Legislature. A Judgment Pursuant to Stipulation, issued April 21, 2004, in the consolidated cases of *Chandler Regional Medical Center, et al. v. California Department of Health Services* and *Arizona Burn Center, et al. v. California Department of Health Services* requires that, effective for days of service on or after January 1, 2004, Medi-Cal rates for acute care inpatient services paid to out-of-state hospitals shall be the lesser of a hospital's actual billed charges or the most recent statewide average of the rates paid to CMAC contract hospitals with at least 300 beds.

The settlement also calls for a $5,500,000 lump sum payment to the hospitals and interest of 7% to be paid beginning January 1, 2004, until the date of payment. The lump sum payment and interest were paid in September 2004. The retroactive rate increase (to January 1, 2004) and the ongoing increase were paid beginning in April 2005.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 52 (PC-18)	X	X	HIV/AIDS Pharmacy Pilot Program

AB 1367 (Chapter 850, Statutes of 2004) required the Department to establish the HIV/AIDS Pharmacy Pilot Program to evaluate the effectiveness of pharmacist care in improving health outcomes. Ten pharmacies are participating and will receive an increase of an additional $9.50 in their dispensing fee for claims with a date of service on or after September 1, 2004. The program sunsets January 1, 2008.

R 53 (PC-52)		X	SNF Rate Changes and Quality Assurance Fee

AB 1629 (Chapter 875, Statutes of 2004) lifts the current rate freeze for freestanding skilled nursing facilities, as well as provides for a cost-of-living adjustment, a change in the rate methodology, and a quality assurance (QA) fee. Rate increases are capped at 8% for FY 2005-06, 5% for FY 2006-07, and 5.5% for each fiscal year thereafter. The QA fee is capped at 6% for each fiscal year. The rate methodology and QA fee provisions sunset on July 31, 2008.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 54 (PC-OA)	X	X	MIS/DSS Contract Procurement

The current contract with MEDSTAT expires April 16, 2006. The Department has initiated procurement activities for a new, competitively bid contract to transfer, enhance, operate and maintain the MIS/DSS. An Acquisition Consultant has been engaged to coordinate procurement activities to ensure that the Department of General Services-run procurement is completed in an efficient and timely manner.

The request for proposal was released in September 2005. A new, four-year MIS/DSS contract, with three one-year extensions, is expected to be executed in June 2006.

The Department will engage an Independent Procurement Oversight Consultant (IPOC) in the ~~fourth~~ **third** quarter of ~~2005~~ **FY 2005-06** and an Independent Verification & Validation (IV&V) Contractor in the first quarter **of FY 2006-07** to provide oversight of the procurement and system transfer processes respectively. ~~The request for proposal is expected to be released in September 2005. A new, four-year MIS/DSS contract, with three one-year extensions, is expected to be executed in March 2006.~~

There will be a six-month contract overlap for the system transfer during which the outgoing contractor will work with the new contractor to ensure an orderly transition to the new operator, and minimal disruption to system users.

A formal MIS/DSS User Development Program will be initiated as part of the implementation of the new MIS/DSS system.

CMS has approved enhanced funding for this project at 75% FFP, with a commitment to consider 90% FFP for project components and planning activities that qualify for enhanced 90% FFP based on details **of the new system. These details will be included** in the Implementation ~~Planning~~ Advanced Planning Document (IAPD) **to CMS, and the Special Project Report (SPR) to DOF,** which ~~is~~ **are** expected to be submitted in ~~January~~ **March** 2006.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 55 (PC-65)	X	X	LTC Rate Adjustments

Pursuant to the State Plan requirements, Medi-Cal rates for long-term care (LTC) facilities are adjusted after completion of the annual rate study. For the rate year 2005-06, new LTC rates will be effective August 1, 2005. Funds will be included for Managed Care, PACE, SCAN, and On LOK. Facilities affected by AB 1629 (freestanding NF-Bs) will undergo a rate methodology change. Any changes to these freestanding NF-Bs will be included in the SNF QA Fee and Rate Change policy change. It is assumed that new LTC rates for rate year 2006-07 will be effective August 1, 2006. The rates for 2006-07 are estimated based on increases from the prior rate year.

R 56 (PC-99)	X		FFP Repayment – Specialty Mental Health Waiver

The Department has agreed to repay CMS for an overpayment within the Specialty Mental Health Services Waiver administered by DMH through an Interagency Agreement with DHS. In its oversight role, DMH identified overpayments to Tri-Cities, a subcontractor of the Los Angeles County Mental Health Plan, of approximately $6.3 million in FFP for Fiscal Years 1996-97, 1998-99, 2001-02, 2002-03, and 2003-04. On February 13, 2004, Tri-Cities, a Joint Powers Authority composed of the cities of Claremont, La Verne, and Pomona, filed Chapter 9 bankruptcy. As part of the bankruptcy proceedings, Tri-Cities identified the total overpayment amount as $9.1 million in FFP. The Department repaid $6.3 million to CMS in FY 2004-05. The audits have been completed, and the total overpayment amount has been determined to be $8.2 million. The remaining $1.9 million due to CMS is expected to be paid in FY 2005-06.

R 57 (PC-89)	X	X	Medi-Cal Reimbursement for Outpatient Small and Rural Hospitals

Health and Safety Code section 124870 requires DHS to increase reimbursement rates for outpatient services rendered to Medi-Cal beneficiaries by small and rural hospitals (SRH). ~~Using the reimbursement methodology identified in the section.~~ The Budget Act of 2000 increased the funding for this program to $4,000,000, or $8,000,000 when matched with federal funds. ~~Prior to January 1, 2005, the Department authorized the FI to increase each eligible hospital's claims by a percentage factor determined by using the methodology specified in statute. In order to provide a more efficient way to reimburse hospitals effective January 1, 2005, eligible~~ **Eligible** SRH providers ~~will be~~ **are** reimbursed on a quarterly basis through a Payment Action Notice (PAN) to the FI. The payment ~~will represent~~ **represents** one quarter of the total annual amount due to each eligible hospital.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 58 (PC-85)	X	X	Medi-Cal Reimbursement for Outpatient DSH SB 2563 appropriated $5,000,000 General Fund to be allocated to hospitals providing a disproportionate share of outpatient services. The total appropriation each year is $10,000,000 when combined with federal matching funds. ~~Prior to January 1, 2005, the Department authorized the FI to increase each eligible hospital's claims by a percentage factor determined by using the methodology specified in statute. In order to provide a more efficient way to reimburse hospitals effective January 1, 2005, eligible~~ **Eligible** DSH providers ~~will be~~ **are** reimbursed on a quarterly basis through a PAN to the FI. The payment ~~will represent~~ **represents** one quarter of the total annual amount due to each eligible hospital.
R 59 (PC-93) (PC-FI)	X	X	Weekly Updates for the Drug Formulary File The Health Trailer Bill of 2005 amended Section 14105.7 of the W&I Code to require the Department to update allowable drug product prices within seven days of receiving notice of a drug product price change, rather than on a monthly basis. As the current medical fiscal intermediary contract requires updating of the formulary file on a monthly basis, a change order will be required for systems modifications to the CA-MMIS. The change from the current monthly price updates to weekly price updates **was effective July 19, 2005 with the chaptering of AB 131, the Health Trailer Bill of 2005. Manual pricing updates occurred August through December 2005 for most drugs, and electronic updates to the formulary began** ~~will be implemented on~~ January 1, 2006. **The Department will retroactively adjust payment for any claims paid incorrectly during the manual pricing update process.**

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 60 (PC-94)	X		*CHA v. Bontá* In the case of the *California Healthcare Association v. Bontá* (San Francisco Superior Court, Case No. 3112880), the Department has agreed to pay a maximum rate of $218.05 per day to hospital-based distinct-part nursing facilities for FY 1996-97. The total costs of $2,700,000 are expected to be paid in FY 2005-06. This lawsuit challenged long term care rates on the basis that they do not comply with the Boren Amendment. The Boren amendment was repealed in 1997; however, the litigation challenges rates established for the rate year August 1, 1996, to July 31, 1997, which were established prior to the repeal of the Boren Amendment. On July 9, 2002, the trial court issued a judgment requiring the Department to recalculate the 1996-97 rates without excluding from the calculation the costs of facilities with less than 20% Medi-Cal days. The judgment also requires the Department to pay the facilities any additional amounts owed based on the recalculated rates.
R 61 (PC-83)	X	X	*Orthopaedic Hospital* Settlement – Laboratory Services The *Orthopaedic Hospital vs. Belshé* settlement required the Department to increase laboratory rates. Based on June 30, 2001 Medi-Cal rates, hospital outpatient rates increased 30% for FY 2001-2002 and an additional 3⅓% each fiscal year through FY 2004-2005 and were reflected in the *Orthopaedic Hospital* Settlement assumption and policy change. The upper payment limit (UPL) for outpatient laboratory services should have been capped at the Medicare rate in place on the date of service to reflect any increases in the Medicare rate. However, the UPL was set at the 2001 Medicare rate and was not updated. In June 2005, the Department updated the outpatient laboratory services rates for 2002 to 2005. ~~Through an EPC~~ **In September 2005**, EDS ~~will begin~~ **began** reprocessing the previously paid claims using the updated rates. **It is estimated that all reprocessed claims will be paid by July 2007.**

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 62 (PC-79)	X	X	Anti-Fraud BIC Card Claims Reprocessing

In an attempt to address Medi-Cal abuse, DHS began issuing new Medi-Cal Benefits Identification Cards (BICs) with new ID numbers to beneficiaries identified as receiving excessive or abnormal health care services in Los Angeles County, effective February 4, 2002. Providers were then required to use the new identification numbers and correct issue dates to have their claims adjudicated. Hospitals, long term care facilities, and certain clinics were excluded from the new billing requirement. Physicians and other providers associated with the excluded entities have encountered difficulties obtaining the BIC ID information from their patients or the excluded entities and subsequently their claims were denied.

To alleviate this problem, new policy was established on February 11, 2005, allowing for exceptions to the billing requirement based on the place of service. The new policy was made effective retroactively for claims with dates of service from February 4, 2002, through February 10, 2005. Starting July 2005, claims from February 2002 through February 2005 will be reprocessed and paid, with the oldest claims being reprocessed first. The reprocessing of claims should be completed by January ~~2006~~ **2007**.

R 63 (PC-OA)	X	X	Immunization Registry

Immunization services are required for Medi-Cal eligibles based on the Title XIX Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions. California Health and Safety Code Section 120440 governs the operation of immunization registries, secure databases of childhood vaccination records that allow medical providers to identify and vaccinate all under-immunized children, including those assisted by Medi-Cal and CHDP. California is covered by nine regional registries that are based in local health departments. The Department currently allocates Local Assistance General Funds in Item 4260-111 for the operation of the regional immunization registries. CMS has determined that funds to operate immunization registries similar to those in California are eligible for 50% match for Medi-Cal related activities under Section 1903(a)(7) of Title XIX. Beginning in FY 2005-06, the Department will claim Title XIX FFP for the Medi-Cal beneficiary related costs of the immunization registry system. The registry cost for non-Medi-Cal children will continue to be funded through current General Funds.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
R 64 (PC-OA)	**X**	**X**	**PIA Eyewear Courier Service**

The Prison Industries Authority (PIA) fabricates the eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an interagency agreement with PIA to reimburse them for one-half of the costs of the courier service that delivers orders between the optical providers and PIA.

R 65 (PC-124) X X Provider 5% Payment Decrease

The Budget Act and Health Trailer Bill of 2003 reduced selected provider payments by 5%, effective January 1, 2004. Acute hospital inpatient services, federally qualified health centers, rural health clinics, outpatient services billed by a hospital, and clinical laboratories were exempted from the payment reductions. A federal court issued a preliminary injunction in December 2003 that prohibited the Department from implementing this payment reduction in fee-for-service Medi-Cal. The Department appealed and on August 2, 2005, the United States Court of Appeals for the Ninth Circuit reversed the federal court preliminary injunction. **On November 30, 2005, the Court of Appeals denied the plaintiffs' request for rehearing.** Thus, the Department ~~is~~ **was** no longer enjoined from implementing the payment reduction. AB 1735 (Chapter 719, Statutes of 2005) amended the implementation date from January 1, 2004, to January 1, 2006. The 5% payment reduction ~~expires~~ **was to have expired on** December 31, 2006.

Exempt from the payment reduction were services provided on or after July 1, 2004 through the California Children's Services Program, the Genetically Handicapped Persons Program, and the Child Health and Disability Prevention Program.

Effective September 1, 2004, reimbursement of prescription and over-the-counter drugs dispensed by pharmacy providers was exempted from this reduction due to implementation of the pharmacy payment reduction on that date. The ~~court order did not affect managed care, and the reduction was applied to managed care rates effective~~ **preliminary injunction did not apply to statutorily required rate reductions for managed care plans. Those rate reductions were implemented effective** January 1, 2004.

The provider payment reduction was implemented on January 1, 2006. With the subsequent passage of SB 912 (Chapter 8, Statutes of 2006), the reduction ended on March 3, 2006, and payments were no longer reduced beginning March 4, 2006.

OTHER: RECOVERIES: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
RC 0.1 (PC-131)	X	X	Estate Recovery Regulations/Exemption

Pursuant to a settlement agreement in the case of *California Advocates for Nursing Home Reform et al. v. Diana M. Bontá et al*., the Department is amending the Medi-Cal estate recovery regulations to make a number of clarifying changes that have potential fiscal impacts. These include: definition of an estate to include retirement accounts and life insurance policies that revert to the State; addition of authority to collect from estates for the cost of institutional care provided to persons under age 55; and addition of an exemption from estate recovery for undue hardship when the person seeking the waiver provided care to the decedent for two or more years while living in the home with the decedent that delayed or prevented the decedent's admission to a medical or long-term care institution. The regulations are expected to be implemented in May 2006.

OTHER: RECOVERIES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
RC 1 (PC-125) (PC-109)	X	X	Anti-Fraud Expansion Based on additional funding provided in the Budget Acts of 2000 and 2003, the Department significantly expanded its provider anti-fraud activities. Specific areas of review and savings include enrollment reviews, laboratory enrollment reviews, field audits (including pre-checkwrite audits, lab audits), reissuance of BICs, and providers who have ceased billing due to withholds, special claims review activities, prior authorizations, and collections. The Department has started the re-enrollment process of providers beginning with selected provider types. The anti-fraud policy changes reflect activities/savings according to the fiscal years in which they began. These policy changes will be incorporated into the base once their impact is reflected in the base trend data.
RC 2 (PC-127)	X	X	Base Recoveries ~~– Third Party Liability Collections~~ **Budget Act Language allows all recoveries to be credited to the Health Care Deposit Fund and to be used to finance current obligations of the Medi-Cal program. Medi-Cal recoveries result from collections from estates, lawsuit settlements, providers, and other insurance to offset the cost of services provided to Medi-Cal beneficiaries in specified circumstances.** Gross Third Party Liability collections are based on trends in actual collections. ~~As mandated by CMS in the Medicaid Manual Update, Transmittal 75, dated January 11, 2001, on March 1, 2001, the Department began adding the cost of Medicare Part A premiums to its estate recoveries. Estate recovery claims will only include Part A premiums paid after March 1, 2001.~~
RC 3 (PC-OA)	X	X	Veterans Benefits AB 1807 (Chapter 1424, Statutes of 1987) permits the Department to make available federal Medicaid funds in order to obtain additional veterans benefits for Medi-Cal beneficiaries, thereby reducing costs to Medi-Cal. An interagency agreement exists with the Department of Veterans Affairs.

OTHER: RECOVERIES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
RC 4 (PC-121)	X	X	New Recovery Activities

The Budget Act of 2005 increased staffing within the Department's Health Insurance and Recovery programs. Staffing augmentation~~s, revision of state laws~~ and replacement of the Recovery Program's Automated Collection Management System (ACMS**)** are proposed to increase collections in the Estate Recovery (ER) and Personal Injury (PI) Units. In addition, proposed staffing augmentations for Health Insurance programs and contracting for other health coverage (OHC) identification will increase private health insurance carrier billings and enrollment in the Health Insurance Premium Payment Program (HIPP), and allow timelier identification of OHC.

The savings areas and their implementation dates are:

1. Recover PI Expenses of Managed Care Beneficiaries; savings start March 1, 2006.
2. Enhance Estate Recovery & Personal Injury Collections; savings start ~~January 1,~~ **December** 2008.
3. a. Other Coverage Unit Augmentation; savings due to deflected payments started November 1, 2005.
   b. Other Coverage Unit Augmentation; savings due to increased recoveries start March 1, 2006.
4. Increase Recoveries from Private Health Insurance Carrier Billings due to creation of the Health Insurance Recovery Group; savings started December 1, 2005.
5. a. Other Health Coverage Identification from Electronic Data Matches; savings due to deflected payments start April 1, 2006.
   b. Other Health Coverage Identification through Electronic Data Matches; savings due to increased recoveries start ~~March~~ **April** 1, 2006.
   c. Increase cost savings resulting from improvements to the Medicare Buy-In System; savings start in two steps, beginning August 1, 2005 and February 1, 2006.

RC 5 (PC-108)		X	Medical Support Enhancements

The Budget Act of 2003 included savings for a Medical Support Enhancement program. The program is designed to extend the IV-D Children program statewide. The IV-D Children program requires (through court orders) absent parents who have private health insurance, or who can afford cost-effective county-acquired insurance, to pay for the health insurance needs of their children. The California Child Support Automation System (CCSAS), which will allow for automated reporting of other health coverage, will be implemented in October 2006.

FISCAL INTERMEDIARY: EDS: NEW ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 0.1 (PC-FI)		X	Elimination of Contractor Staff Utilized for the Enhancement of CMS Net

The Children's Medical Services Network (CMS Net) is the automated eligibility, medical case management, and client tracking system for the California Children's Services (CCS) Program. Four contractor staff were assigned to assist in a multi-year effort to enhance CMS Net through the provision of electronic linkages to the Medi-Cal Eligibility Data System (MEDS), the California Medicaid Management Information System (CA-MMIS), Dental CA-MMIS and the Health Insurance System (HIS) third party liability recovery system. As CMS Net transitions from development to an ongoing maintenance and operations phase with completion of the electronic interface of the CMS Net and CA-MMIS, this work will be transferred to State staff.

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 1 (PC-FI)	X	X	California Children's Services Claims/Enhancement

The CMS Net/E47 Project, which provides linkage between the CCS automated case management system and the California Medicaid Management Information System (CA-MMIS) and the California Dental Medicaid Management Information System (CD-MMIS), was implemented on July 1, 2004. CMS Net is an automated case management system that is being used by 55 CCS counties, three State CCS regional offices, and GHPP. The Legislature has directed the CCS program to assist county CCS programs not yet participating in CMS Net to make the transition to the system. The three remaining counties, Los Angeles, Orange, and Sacramento include a significant portion of the CCS provider population and over 40 percent of the State's CCS clients.

The prospective transition of the three remaining counties to CMS Net requires a specialized education and outreach effort to be conducted by the fiscal intermediary contractor's provider relations staff. This will ensure that providers are sufficiently proficient in the use of the new systems to avoid reduction or delays in services to CCS clients. The systems costs are shared between the Medi-Cal, CCS State-Only and CCS Healthy Families programs.

FI 2 (PC-FI)	X	X	Insurance Identification Contracts

The Department contracts with vendors to identify recipients with other health coverage. Since Medi-Cal is the payer of last resort, other health plans must first be billed before the Medi-Cal program. The Department contracts provide: 1) data matches between the Department's Medi-Cal Recipient Eligibility file and the contractor's policy holder/subscriber file; 2) identification and recovery of Medi-Cal expenditures in workers' compensation actions; 3) identification of private/group health coverage and the recovery of Medi-Cal expenditures when the private/group health coverage is the primary payer; 4) online access to research database services for public records of Medi-Cal recipients; and 5) cost avoidance activities.

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 3 (PC-FI) (PC-116)	X	X	EDS Cost Containment Proposals – Savings Sharing The Department continues to review and approve EDS-initiated cost containment proposals, implementing as appropriate to contain Medi-Cal costs. Savings are achieved, with EDS continuing to receive a share of the savings. Additionally, the Contractor continues the process of identifying fraudulent claims activity in two areas – outpatient (physician, DME, lab, pharmacy, etc.) and prepayment review. As other areas are identified, they will be further developed. The savings methodology is linked to actual cost avoidance and/or realized recovery of fraudulent payments to providers. The Contractor has developed a program to formalize the identification of fraudulent claims activity, facilitate appropriate intervention with various audit organizations, recommend system or policy modifications, if appropriate, and support regulation development, if necessary, to support efforts by the Department to expeditiously stop illegal and inappropriate payment activity. The staffing is provided by the Contractor.
FI 4 (PC-FI)	X	X	Point of Service (POS) Network Refresh The Department's POS network allows providers to swipe the plastic Medi-Cal card through a POS device to determine a recipient's monthly eligibility. Under the POS Network Refresh Project, the Department replaced the POS Network telecommunication infrastructure and POS devices. An Advanced Planning Document (APD) and APD Updates have been submitted to CMS and approved for enhanced funding for this project. The POS Network telecommunications infrastructure was completed in January 2003. Statewide replacement of devices began February 2003. The Pharmacy application was remotely downloaded by providers in early September 2003 and the 837 Professional Claim application went to providers in November 2003. The FPACT application software was remotely downloaded by providers in August 2004. Dial up and Leased Line Third Party Vendor Specifications were published on the Medi-Cal Web site in December 2004. ~~Starting in June 2005, a new Operating System is being remotely downloaded by providers. As of August 2005, downloads are 87% complete.~~ **Downloads of the new operating system have been completed.** The old Hypercom system was decommissioned in October 2005.

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 5 (PC-FI)	X	X	HIPAA – Provider Relations

Provider relations is an essential component of the activities relating to HIPAA. Additional EDS staffing will be necessary to obtain appropriate provider feedback on proposed HIPAA changes and to provide technical assistance specific to the many CA-MMIS and claims processing changes resulting from these projects. Clear and accurate communication is vital and will be supplemented by provider bulletins, seminars and interactive workshops, and other notices via mail and the Internet. This activity is in addition to those provider relations activities already funded in the FI fixed price contract.

EDS staff will be utilized to accommodate increased suspense rates and provider appeals with each code conversion and claim transaction while providers become accustomed to the changes.

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal program, the Department has developed a phased-in approach to implement the most critical (in terms of provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation was in September 2003. The remaining transactions and code conversions will continue to be phased-in.

FI 6 (PC-FI)	X	X	BIC Production and Postage

Costs for production and mailing of Medi-Cal Benefits Identification Cards are paid through the Fiscal Intermediary.

FI 7 (PC-FI)	X	X	Expansion of Drug Rebate Program

As part of the FY 2002-03 Medi-Cal expenditure reduction proposals, per the Health Trailer Bill of 2002 (AB 442, Chapter 1161, Statutes of 2002), up to four contract Pharmaceutical Consultant positions are authorized to perform the same duties as State-employed Pharmaceutical Consultants.

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 8 (PC-FI)	X	X	CHDP Gateway Project

The Health Trailer Bill of 2002, (AB 442, Chapter 1161, Statutes of 2002), includes provision for children receiving a CHDP screen to be preenrolled in Medi-Cal/Healthy Families (full-scope Medi-Cal services) for two months of coverage during which time the family may apply for ongoing Medi-Cal/Healthy Families coverage. This legislation required that the Department develop an electronic transaction for the enrollment of CHDP children and mail a Medi-Cal/Healthy Families application to families interested in ongoing coverage. The CHDP Gateway electronic enrollment application was developed on the Medi-Cal Internet website and on the POS device and implemented July 1, 2003. The second phase of this project, required by the Health Trailer Bill of 2003 (AB 1762, Chapter 230, Statutes of 2003), included changes to the CHDP Gateway electronic enrollment to allow for the automatic enrollment of deemed infants into Medi-Cal. The changes were implemented on June 1, 2004. The Medi Cal FI incurred costs for the development of the deemed infants electronic transaction, and will continue to incur other costs in the implementation, maintenance, and operation of this program. Initially, the CHDP Gateway program required significant provider education, training and support.

The activities are funded through a change order to the FI contract.

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 9 (PC-FI)	X	X	HIPAA – CA-MMIS

HIPAA requires uniform national health data standards, unique identifiers and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff are required to provide for remediation/implementation of HIPAA changes to the California Medicaid Management Information System (CA-MMIS) and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). The advance planning document updates (APDU's) have been submitted to CMS and were approved for enhanced funding for Transactions and Code Sets, Security, and high-level work on other rules. APDUs will continue to be submitted as new rules are published to continue to secure enhanced funding.

The work necessary is associated with the following HIPAA regulations:

- Privacy (April 14, 2003 compliance deadline)
- Transactions and Codes (October 16, 2003 compliance deadline)
- Unique Employer Identifier (July 30, 2004, compliance deadline)
- Security (April 21, 2005, compliance deadline)~~*~~
- National Provider Identifier (May 23, 2007 compliance deadline)~~*~~
- Electronic Signature (Notice of Proposed Rule Making (NPRM) pending, originally part of Security NPRM)
- Enforcement (Interim rule published)
- National Health Plan Identifier (NPRM pending)
- Claims Attachments (NPRM pending)
- First Report of Injury (NPRM pending)
- Transactions and Code Sets Clarification (NPRM Pending)

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department has developed a phased-in approach to implement the most critical (in terms of provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation was in October 2003 and the second phase of implementation was in October 2004. The ~~next~~ **third** phase of implementation ~~is~~ **was in** October 2005, and the remaining transactions and code conversions will continue to be phased-in and implemented after October 2005.

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 10 (PC-FI)	X	X	HIPAA UPN Exception Request

The Department has received from CMS approval of a waiver request for an exception to the HIPAA mandate requiring the exclusive use of the HCPCS codes for medical supplies. CMS has approved, under an existing APD for enhanced FFP, funding from 75 percent to 90 percent for the Department to procure the UPN Repository Vendor and a system assessment. The FI Contractor is being directed to prepare a Request for Proposal (RFP) to procure the UPN Repository Vendor and review CA-MMIS to determine a complete system impact and development timeline. Another APD request for enhanced funding has been submitted to CMS requesting 90 percent FFP to cover development and hardware costs. The expected implementation date is December 30, 2007.

FI 11 (PC-FI)	X	X	SSN Use on Benefits Identification Cards

SB 25 (Chapter 907, Statues of 2003) prohibits the printing or embedding of an individual's Social Security Number (SSN) on a Medi-Cal Benefits Identification Card (BIC). The SSN has been the beneficiary ID on the BIC card since the plastic BIC cards were issued in 1994. The Department began reissuing BICs with a new 14-digit ID number to over 6.5 million Medi-Cal beneficiaries beginning in January 2005 and completed the statewide reissuance before the July 1, 2005 SB 25 compliance date. The new 14-digit ID contains a 9-digit Client Index Number (CIN), a check digit, and a 4-digit issue date. ~~The Medi-Cal fiscal intermediary implemented systems changes in January 2005 to accept the new 14-digit ID and process it as a 10-digit CIN until 1) the statewide BIC reissuance was completed and 2) system changes required to prohibit the use of the SSN for eligibility inquiries and for Medi-Cal billing (AB 3029) could be implemented.~~ **The systems changes to accept and process the full 14-digit ID in CA-MMIS and the eligibility verification systems were completed October 24, 2005.**

AB 3029 (Chapter 584, Statutes of 2004) requires providers to use the new 14-digit ID for billing Medi-Cal, but excludes certain providers and services from this billing requirement. Excluded providers will be allowed to continue to use the SSN for billing. ~~The AB 3029 billing requirements will be implemented in phases.~~ **Providers have been instructed to use the new 14-digit ID; however, compliance is currently voluntary. The system changes required to enforce AB 3029 compliance are scheduled to begin in October 2006.**

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 12 (PC-FI)	X		AEVS/PTN/CMC Operating System Upgrade As a result of Microsoft no longer supporting the Windows NT Operating system, an operating system upgrade will be needed for the continued operation of the Medi-Cal FI interactive voice response systems which include the Automated Eligibility Verification System (AEVS), Provider Telecommunications Network (PTN), and the Computer Media Claims (CMC) all of which use Windows NT. Microsoft has notified its customers that Microsoft support ended on December 30, 2004. **Work is scheduled to be completed by the third quarter of FY 2005-06.**
FI 13 (PC-FI)	X		Drug Rebate Accounting and Information System (RAIS) Equipment Refresh The Drug Rebate Accounting and Information System (RAIS) supports annual invoicing of ~~over $1 billion in~~ rebates on drugs, **biologicals and medical supplies**. ~~and blood factors provided by the Medi-Cal program. The RAIS production system was implemented in 2001 and has collected over $4 billion in drug rebates. This system is used for invoicing drug rebates and tracking payment collections.~~ The production platform is ~~near~~ **at** the end of its useful life period and is in need of equipment refresh. ~~Memory storage is reaching maximum capacity while hardware components are starting to fail due to age of equipment. In addition, the PC and Imaging equipment for the FI Contractor Drug Rebate Unit needs to be replaced due to age of the equipment. The FI Contractor is being directed to evaluate all production equipment used for Drug Rebates and determine which components need to be replaced within the 2005-06 Fiscal Year.~~ **In addition, much of the software for the RAIS is outdated and no longer supported by the software vendors. Purchase of all needed hardware and software for the refresh will be done in FY 2005-06. All other implementation costs are being absorbed in the FI contract budget.**

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
FI 14 (PC-FI)	X	**X**	CA-MMIS Assessment

California Medicaid Management Information System (CA-MMIS) is the Claims Processing System used for Medi-Cal. Over 20 years of changes to CA-MMIS to incorporate technological advances as well as to address new business and legislative requirements has contributed to a system that is extremely complex. Because of the importance of the system in assuring timely and accurate claims processing for the 80,000 Medi-Cal providers, the age of the system, and the size and complexity of the system, an assessment of the system is needed to help guide DHS in planning the future direction of the CA-MMIS system. **A business case justification was submitted on April 18, 2005.** ~~DHS plans to contract~~ **The Department is contracting** for the CA-MMIS assessment using the California Multiple Award Schedule (CMAS) contractor list. **The CA-MMIS assessment is expected to be completed by June 30, 2006.**

Note: Additional EDS Fiscal Intermediary Costs are included in the following Assumptions:

- Weekly Updates for the Formulary File
- Medicare Modernization Act Part D Drug Prescription Program
- Drug Budget Reduction
- *Conlan v. Bontá; Conlan v.Shewry*

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: NEW ASSUMPTIONS

Applicable F/Y	
C/Y	B/Y

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
HO 1 (PC-FI)	X	X	Notices to Voluntary Aid Code Beneficiaries **/** Threshold Languages

State Medicaid programs that include managed care components are required by the regulations implementing the Balanced Budget Act of 1997 (42 CFR, Part 438.10), to notify all new potential eligibles in voluntary aid codes that they have the option to enroll in a managed care plan. Initial changes completed June 1, 2004 include identifying, informing, and enrolling/disenrolling voluntary aid code beneficiaries. New informing materials for this new population have been developed and are being sent to voluntary beneficiaries. The Medi-Cal Managed Care Division (MMCD) added four new threshold languages and deleted one existing threshold language. All informing materials, including the Notices to Voluntary Aid Code beneficiaries, and all associated Call Center and Presentation Site scripts, have been translated into the four new languages. These changes have increased the cost of HCO operations. Some of these costs will be covered under a change order.

In the past, Notices to Voluntary Aid Code Beneficiaries and Threshold Languages were separate projects and separate assumptions. HCO has since directed the HCO contractor to combine these projects to eliminate production duplication.

HO 2 (PC-FI)	X	~~X~~	Consumer Guide on Quality for Medi-Cal Managed Care Beneficiaries

The Balanced Budget Act of 1997 (42 CFR, Part 438.10(i)(3)(iv)), requires states with Medicaid managed care delivery systems to provide potential enrollees with information about the health plans available to them. The California Medi-Cal Managed Care Program will augment the health plan information currently provided in its enrollment packets to include a consumer guide which compares health plan performance across several key areas. ~~There will be~~ **This project has** increased costs for printing, **postage** and integrating health plan consumer guides into the existing enrollment packets. ~~The implementation date for this~~ **This** project was **implemented in** September 2005.

HO 3 (PC-FI)		X	Informing Materials for Beneficiaries with Disabilities

The Balanced Budget Act (BBA) of 1997, as implemented by 42CFR 438.10(d), states, “written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.” This requirement originated in the Americans with Disabilities Act, which was incorporated into the BBA. HCO’s current informing materials do not comply with this requirement. HCO will need to revise the existing informing materials for beneficiaries with disabilities, which will result in increased costs for translations, printing, and postage. Implementation for this project is anticipated in June 2007.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
HO 4 (PC-FI)	X	X	Two-Plan Model Reprocurement

The Medi-Cal Managed Care Division is in the process of reprocuring the managed care health plan contracts in the Central Valley, Bay Area and Southern California Two-Plan model counties. The process resulted in Commercial Plan contract changes in Stanislaus **and Kern** ~~Riverside and San Bernardino~~ Counties. **All the new contracts became operational with the exception of Riverside and San Bernardino Counties.** HCO ~~has begun the process of notifying~~ **sent notification of commercial plan changes to** Medi-Cal beneficiaries in ~~these counties of commercial plan changes~~ **Stanislaus and Kern Counties.** The development, production and mailing of the notices and revised informing materials ~~have resulted~~ **will result** in increased HCO costs.

HO 5 (PC-FI)		X	Turnover of Existing Health Care Options Contract

The Turnover period is to ensure an orderly transfer of the Health Care Options contract from the current contractor to the State or successor contractor at the end of the contract (Extension Year 3 ends September 30, 2007). Turnover activities begin July 1, 2006, fifteen months prior to the end of the contract.

HO 6 (PC-FI)	X	X	HIPAA Security Health Care Options

Based on its contract with the Department, Health Care Option's enrollment broker, MAXIMUS, is required to comply with HIPAA of 1996. MAXIMUS is performing HIPAA Privacy and Security Risk assessments, including gap analyses, and will remediate identified deficiencies.

FISCAL INTERMEDIARY: DELTA DENTAL: NEW ASSUMPTIONS

Applicable F/Y	
C/Y	B/Y

FISCAL INTERMEDIARY: DELTA DENTAL: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
DD 1 (PC-FI)	X	X	HIPAA – CD-MMIS

HIPAA of 1996 requires uniform national health data standards, unique identifiers, and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff are required to provide for remediation/implementation of HIPAA changes to the California Dental Medicaid Management Information System (CD-MMIS) and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). An Advance Planning Document Update (APDU) was submitted on April 29, 2004 to CMS and approved for enhanced funding of Transactions and Code Sets. APDs will continue to be submitted as new rules are published to continue to secure enhanced funding.

The work necessary is associated with the following HIPAA regulations:

- Privacy (April 14, 2003 compliance deadline)
- Transaction and Code Sets (October 16, 2003 compliance deadline)
- Unique Employer Identifier (July 30, 2004 compliance deadline)
- Security (April 21, 2005 compliance deadline)
- National Provider Identifier (May 23, 2007 compliance date) (This will require a separate change order.)
- Electronic Signature (Notice of Proposed Rule Making (NPRM) pending, originally part of Security NPRM)
- Enforcement (Interim rule published)
- National Health Plan Identifier Standard (NPRM pending)
- Claims Attachments (NPRM pending)
- First Report of Injury (NPRM pending)

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department was not fully compliant with HIPAA by the October 2003 federally mandated implementation date for transactions and code sets. The Department is phasing in transactions, implementing the most critical ones first (in terms of provider impact). Dental procedure codes are 100 percent local codes that will be converted to the national CDT-4 codes. This complex effort is underway and will extend into 2006.

A high-level assessment on Denti-Cal operations and CD-MMIS is in process regarding the adoption and implementation of the NPI. Efforts are underway to meet the May 2007 compliance date.

FISCAL INTERMEDIARY: DELTA DENTAL: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
DD 2 (PC-FI)	X	X	Dental Contract Takeover Costs

Takeover activities for the new dental contract commenced December 2004. Payments for Takeover started in January 2005. As a result of the incumbent also being the successor contractor, certain Takeover tasks were deleted per Amendment 01 of Contract 04-35745. There was a commensurate price reduction to the original bid price for Takeover. **Takeover was delayed pending resolution of a contract issue regarding the leveraging of State assets from one contract to another. While this delay will not result in the need for any new dollars, it will result in shifting some takeover payments which were originally anticipated to be paid in FY 2004-05 and FY 2005-06, to FY 2006-07.**

DD 3 (PC-FI) X Delta Dental Enrollment Staff

SB 857 (Chapter 601, Statutes of 2003) which allows the Department to more effectively combat fraud through more stringent provider enrollment requirements in order to participate in the Medi-Cal program, and the requirement of the new Disclosure Statements, have dramatically increased the processing times and workload for the Denti-Cal enrollment process. Enrollment timeframes have grown from an average of 120 days to approximately 180 days over the last fiscal year. Based on the current growth, enrollment time frames will exceed the 180 day limit within the next six months. State statutes require that applications be processed within 180 days. In order to comply with state statutes, the Fiscal Intermediary Provider Enrollment staffing will be augmented up to the maximum allowable within contractual authority.

FISCAL INTERMEDIARY: DELTA DENTAL: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
DD 4 (PC-FI)	X	X.	System Replacement for California Dental Management Information System (CD-MMIS)

The dental claims processing contract was recently awarded to Delta Dental, the incumbent. The request for proposal was for the takeover of the existing Denti-Cal fee-for-service program and related systems. In an effort to reduce future bid prices, the Department will seek to increase the competition for the next contract procurement by bringing the antiquated CD-MMIS legacy system architecture into more widely supported current technology standards. Additionally, it is envisioned that this new system will automate claims adjudication processes that are currently performed manually. The system will meet all Medicaid Information Technology Architecture requirements and will be eligible for federal certification. ~~The federal government has approved this proposal in concept and is awaiting our advanced planning document for review. Once approved, the federal participation will be 90% FFP/10% GF for design, development and implementation of this system.~~

~~The first step is to gain~~ **A business case justification was approved by the** Office of Technology Review, Oversight and Security (OTROS). ~~acceptance through submission of a Business Case Justification, and then~~ **The Department will now seek to gain** CMS approval by developing an Advanced Planning Document (APD). The work on the APD will begin in early 2006. This APD will provide a gap analysis between the proposed solution and the existing system capabilities and processes. **Once approved, federal participation will be 90% FFP/10% GF for design, development and implementation of this system**. ~~Upon approval of the APD, the~~ **The** Department will **then** direct Delta to secure sub-contracts to perform Independent Verification and Validation (IV&V) and project management services. Delta will be reimbursed under the Cost Reimbursement provisions of the contract.

FISCAL INTERMEDIARY: DELTA DENTAL: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
DD 5 (PC-FI)	X	X	Telephone Service Center Minutes (TSC) The Department is anticipating negotiating a change order to establish new billing rates for the TSC. Based on current contract volumes, current projections indicate that the contractor will exceed the high end of the maximum range by month nine of the current contract. Per Contract #04-35745, the TSC minutes in excess of the maximum range will be paid at the current maximum range rate until a change order is processed establishing new rates.

Note: Additional Delta Dental Fiscal Intermediary Costs are included in the following Assumptions:

- $1,800 Dental Cap for Adults
- *Conlan v. Bontá; Conlan v. Shewry*

INFORMATION ONLY:

GENERAL FUND REVENUES

1. The State General Fund is expected to receive the following revenues from quality assurance fees (accrual basis):

FY 2004-05:	$ 25,155,000		ICF-DD Quality Assurance Fee
	~~$118,206,000~~	**$115,634,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	~~$143,361,000~~	**$140,789,000**	Total
FY 2005-06:	$ 27,582,000		ICF-DD Quality Assurance Fee
	$216,852,000		Managed Care Quality Improvement Assessment Fee
	~~$236,413,000~~	**$231,267,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	~~$480,847,000~~	**$475,701,000**	Total
FY 2006-07:	$ 28,503,000		ICF-DD Quality Assurance Fee
	$220,650,000		Managed Care Quality Improvement Assessment Fee
	~~$248,233,000~~	**$242,831,000**	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	~~$497,386,000~~	**$491,984,000**	Total

ELIGIBILITY

1. Cash Assistance Program for ABD Legal Immigrants

   Based on the provisions of PRWORA, certain aliens would have had their SSI/SSP benefits terminated and lost their categorical linkage to Medi-Cal effective October 1, 1998. These beneficiaries were grandfathered by federal legislation. AB 2779, a trailer bill to the 1998 Budget Act, establishes a state-only cash assistance program for aged, blind and disabled legal immigrants who meet the SSI/SSP immigration status requirements that were in place in August 1996 and all other current SSI/SSP requirements. There is no automatic linkage to Medi-Cal for persons eligible under this cash grant program. They must meet current Medi-Cal eligibility requirements. MEDS changes were made so that persons who are eligible for Medi-Cal and a cash grant under this program can be easily identified.

INFORMATION ONLY:

2. Impact of SB 708 On Long-Term Care for Aliens

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-2000 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to new applicants. Because the current state-only long-term care program is available to eligible new applicants and does not include the expenditure limit, the Department is taking steps to bring the current program into conformance with SB 708. This will require the Department to rescind outdated regulations, and implement new regulations to define the spending limit and to clarify other implementation requirements. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-2000 base year, no fiscal impact is expected in FY 2005-06 and FY 2006-07 due to the spending limit.

3. Additional Disabled Recipients Off SSI/SSP

The SSA continues to increase the number of continuing disability reviews on disabled persons. As a result, many more SSI/SSP recipients are being found no longer disabled. This has resulted in the termination of approximately 800 SSI/SSP recipients each month. Under federal regulation, Medi-Cal eligibility must be continued for these individuals while their SSI/SSP appeal is pending. This appeal process can take from 12 months to 3½ years. The State must track the SSI/SSP appeal process so that once the appeal process is exhausted, the counties can make a determination of Medi-Cal eligibility under another Medi-Cal category. The cases will be under aid code 6N while the appeal on the disability cessation is pending. Effective April 2003, the No Longer Disabled population undergoing the appeal process with SSA can be identified and tracked through MEDS. This population will remain in aid code 6N through the appeal process and be assigned a Pickle type indicator of "D". If the appeal is lost or exhausted, MEDS will place the beneficiary in aid code 6E, so they can be tracked on an exceptions eligible report, developed as a result of the *Craig v. Bontá* lawsuit.

4. Communications Between Managed Care Plans and County Welfare Departments

SB 87 (Chapter 1088, Statues of 2000) establishes that the Department, in consultation with the counties, consumer advocates, managed care plans and Medi-Cal providers, conduct a feasibility study on adopting a mechanism that allows counties to notify a managed care plan whenever a beneficiary enrolled in their plan is to have their annual Medi-Cal eligibility redetermination.

Counties are to undertake outreach efforts in maintaining contact with Medi-Cal beneficiaries to ensure home addresses and telephone numbers are current so that eligibility forms to be completed by the beneficiary are forwarded correctly and submitted timely. Managed care plans will be encouraged to report updated beneficiary contact information with county staff. The updated contact information is to be limited to a beneficiary's change of address, change of name, and telephone number. The Department is required to develop a consent form used by counties to record the beneficiary's consent permitting the county to use updated contact information received from the managed care plan to update their case file. The Department finalized the consent form and released it to the health plans in January 2003 and to the counties in March 2003. The Department is providing the annual redetermination information to managed care plans on the monthly eligibility tapes that plans receive each month for their enrollees.

INFORMATION ONLY:

5. Accelerated Enrollment for Foster Care

AB 430 (Chapter 171, Statutes of 2001), the budget trailer bill (BTB), added Section 14007.45 to the W&I Code to require the Department to submit for federal approval, a SPA to implement accelerated eligibility for children just entering the foster care system. The federal law does not authorize limiting presumptive eligibility (PE) to one eligibility group such as foster care children; thus, it is unlikely that the federal government would approve such an amendment. The statute specifies that if federal participation is not available for the accelerated eligibility, the Department is to instruct counties to establish procedures to expedite eligibility determinations for children entering the foster care system. The Department distributed ACWDL Number 01-41 in July 2001 which directs the CWDs to expedite Medi-Cal eligibility as soon as a detention order has been issued by a court. The SPA is under development and will be submitted to CMS.

6. Qualifying Individual Program

The Balanced Budget Act of 1997 provided 100% federal funding effective January 1, 1998, to pay for Medicare premiums for two new groups of Qualifying Individuals (QI). QI–1s have their Part B premiums paid and QI-2s receive an annual reimbursement for a portion of the premium. The QI programs were scheduled to sunset December 31, 2002, but only the QI-2 program did sunset December 31, 2002. ~~The QI-1 program was extended through September 2004 and later extended again to September 30, 2005.~~ The President's Budget proposes extending the program through September 30, 2006.

7. Extension of the Sunset Date of the 250% Working Disabled Program

Effective April 1, 2000, AB 155 (Chapter 820, Statutes of 1999), established the 250% Working Disabled Program, a Medi-Cal program for disabled persons who are employed and have family income below 250% of the federal poverty level (FPL). To be eligible, persons must meet SSI/SSP eligibility criteria except for income from earnings and pay a monthly premium: $20 to $250 for individuals and for couples, $30 to $375. The program was due to sunset effective April 1, 2005. The Health Trailer Bill of 2004 extended the sunset date to September 1, 2008.

8. Curtailing Asset Shelters

SB 620 (Chapter 547, Statutes of 2003) placed restrictions on the marketing of annuities to persons age 65 or older if the purpose is to affect Medi-Cal eligibility. Proposed regulations will place additional restraints on the transfer of assets to qualify for Medi-Cal, the sheltering of assets of otherwise resource-ineligible individuals, and the sale of annuities to individuals who are receiving services under a Section 1915(c) waiver, nursing facility level of care in a medical institution or nursing facility care.

INFORMATION ONLY:

9. Domestic Partners on Medi-Cal

Assembly Bill 205 (Chapter 421, Statutes of 2003) requires that registered domestic partners shall have the same rights, protections, and benefits, and shall be subject to the same responsibilities, obligations, and duties under law, whether they derive from statutes, administrative regulations, court rules, government policies, common law, or any other provisions or sources of law, as are granted to and imposed upon spouses. AB 205 also provides that it does not amend or modify federal laws or the benefits, protections and responsibilities provided by these laws.

Because domestic partner relationships are not recognized in federal laws and regulations, there is no federal reimbursement for any expenditure based on domestic partner relationships. Since California is establishing Medi-Cal benefits based on domestic partnership, it will only apply to the existing State-only Medi-Cal program and costs solely existing due to domestic partnerships will be State-only funded. The costs are expected to be insignificant.

10. Transitional Medi-Cal Program

As part of Welfare Reform in 1996 (PRWORA of 1996, P.L. 104-193), the Transitional Medi-Cal Program (TMC) became a one-year federal mandatory program for parents and children who are terminated from the Section 1931(b) program due to increased earnings from employment. Prior to this current twelve month program, TMC was limited to four months for those discontinued from the Aid to Families with Dependent Children program due to earnings. Since 1996, it has had sunset dates that Congress has continually extended. Its current sunset date is September 30, 2006.

11. Newborn Hospital Gateway

SB 24 (Chapter 895, Statues of 2003) requires DHS to adopt an electronic Newborn Hospital Gateway process for families to enroll a “deemed eligible for Medi-Cal” newborn into Medi-Cal from hospitals that have elected to participate in the process, to the extent that up to three staff and funding from non-state entities is made available to DHS for this purpose. The Medi-Cal Fiscal Intermediary will develop and maintain this electronic enrollment process. Additionally, for enrollment of a child under the age of one year deemed to have applied and be eligible for Medi-Cal benefits, the enrollment procedures of the Newborn Hospital Gateway shall specifically include procedures for confirming the eligibility of, and issuing a BIC to, that child. Since this activity requires special funding in the form of a grant, it will begin when the staffing and funding become available. The Department is exploring funding options. SB 29 (Chapter 148, Statutes of 2004) allows DHS twelve months from the time staffing and funding are available to implement.

12. Prenatal Gateway

SB 24 (Chapter 895, Statues of 2003) requires DHS to adopt an electronic Prenatal Gateway process which allows qualified providers to grant immediate, temporary Medi-Cal coverage to low-income, pregnant patients pending their formal Medi-Cal application and eligibility determination, to the extent that up to three staff and funding from non-state entities is made available to DHS for this purpose. In order to complete these changes to the current paper process, additional funds are required in order to hire contracting staff to make the necessary changes to the Medi-Cal Eligibility Data System (MEDS), which resides at the Health and Human Services Data Center. Since this activity requires special funding in the form of a grant, it will begin when the staffing and funding become available. The Department is exploring funding options. SB 29 (Chapter 148, Statutes of 2004) allows DHS twelve months from the time staffing and funding are available to implement.

INFORMATION ONLY:

13. ISAWS Migration to C-IV

The Health and Welfare Data Center has proposed migrating the thirty-five counties using the ISAWS eligibility system to the C-IV eligibility system. This system is newer and has many features not available in ISAWS. Proposals have been discussed with the counties and various state agencies, including the Department of Finance. Although all the General Fund migration costs are budgeted through the Data Center and the State Department of Social Services, there are some additional county administrative expense costs which need to be accounted for in the Department of Health services budget.

These costs have been estimated to be $30 million per fiscal year. The actual cost per year will be less than that amount since the migration will have a staggered start. The first county for ISAWS migration is not scheduled at this time. The migration is expected to begin sometime in the latter part of FY 2007-08.

14. County Liability for Federal Disallowances

The Department is proposing trailer bill language that will make CWDs financially liable for 100% of any federal penalty or disallowance the Department experiences that results from the failure of the CWD to comply with the policies, rules and regulations of the Medi-Cal program. Any such liability shall be apportioned among the CWDs based upon the extent to which each CWD was responsible for the failure to comply with the policies, rules and procedures of the Medi-Cal program.

15. Federal Deficit Reduction Act – Citizenship Verification Requirement

The May Revision includes trailer bill language to implement a provision of the federal Deficit Reduction Act of 2005 requiring, as a condition of receiving federal funds, that the Medi-Cal program verify the citizenship of those individuals who declare that they are citizens of the United States. Under this new provision, these individuals are required to show proof of identity and citizenship at the time of application and upon redetermination. This language will require the Department of Health Services to utilize as many alternate sources of verification as allowed under federal rules. This provision does not apply to, or otherwise affect, people who are applying for Medi-Cal as immigrants. Budget bill language has also been proposed to allow the Department to move available funding from Medi-Cal Benefits and the Fiscal Intermediary if needed to fund the county administrative cost of completing this verification requirement.

INFORMATION ONLY:

BENEFITS

1. Civil Rights of Institutionalized Persons Act

   Subsequent to the *Davis* lawsuit, which was recently settled between the Department and advocates for community long-term care, the United State Department of Justice (USDOJ) forwarded a letter to Governor Schwarzenegger on August 3, 2004. This letter outlined the USDOJ's concerns regarding inappropriate institutionalization of people at Laguna Honda Hospital (a large 1200 bed nursing facility in San Francisco). This inquiry falls under the USDOJ's probe under the Civil Rights of Institutionalized Persons Act (CRIPA). The USDOJ is requesting that state departments reply to the allegations and commit to significant changes in the way in which people are authorized for, discharged, and diverted from nursing facilities.

   The Department's Office of Legal Services is lead on this response and interactions with the USDOJ. Plans are underway for a summit with USDOJ and the other parties to this inquiry; a date has not yet been set. The Department anticipates that significant changes may be required in the manner in which Medi-Cal authorizes NF TARs, as well as in the process of licensing and certification of nursing facilities in California. While this inquiry is restricted to Laguna Honda at this point, the concepts of state-wideness and comparability under the federal Medicaid Program will eventually require that any changes made at Laguna Honda will be required for all nursing facilities statewide. These changes will result in significant costs to the Medi-Cal program.

2. Screening for Complications of Obesity

   In conjunction with the efforts being made by the Administration to combat obesity and the health impacts it has on the population, the Department is proposing the addition of fasting blood sugar and cholesterol screening as part of the CHDP health assessments when it is indicated. These screens are being added to allow for early identification and treatment of health risks to children and adolescents. The additional screening and education will ultimately result in better health outcomes for children, particularly for those at risk for the onset of Type II diabetes. Although it would be difficult to identify immediate savings, these better health outcomes will result in health care cost savings throughout the life of those screened and treated.

3. Step-Care Drug Therapy, Part 2

   The Budget Act of 2003 includes funding to implement a Step-Care Drug Therapy Program in Medi-Cal. This program is designed to encourage prescription-prescribing providers to use more effective and less expensive drugs before more expensive drugs are used. Initially Medi-Cal was to begin an arthritis drug protocol program that, when fully implemented, was expected to save approximately 10% of the total gross expenditures for arthritis medications annually. With the withdrawal of COX-2 inhibitors from the market, the arthritis drug protocol program has been delayed for an indeterminate period. Future drug protocols are being developed.

INFORMATION ONLY:

4. Assisted Living ~~HCBS~~ Waiver **Pilot Project**

AB 499 (Chapter 557, Statutes of 2000) required the Department to submit an HCBS waiver to CMS to test the efficacy of providing Assisted Living as a Medi-Cal benefit for elderly and disabled persons in two settings, Residential Care Facilities for the Elderly (RCFEs), and Publicly Subsidized Housing (PSH). **In June 2005,** CMS approved the Department's Assisted Living Waiver **Pilot Project (ALWPP)** application ~~in June 2005~~**, effective January 1, 2006**. ~~Assisted Living Waiver Pilot Project (ALWPP) implementation is scheduled to begin January 1, 2006, in Sacramento, San Joaquin, and Los Angeles Counties.~~ **The ALWPP began providing services to beneficiaries in April 2006.** It is anticipated that the ALWPP will serve up to 1,000 persons over its three-year term **in the three pilot counties—Los Angeles, Sacramento, and San Joaquin**. At this time, there is not enough information available to calculate the budget impact.

5. Pediatric Palliative Care

The CCS program is working together with the Medi-Cal program and the Children's Hospice and Palliative Care Coalition to develop a program of services to provide palliative care services and supports for children with life-threatening illnesses as an alternative to parents seeking election into hospice care. The identified services would be provided under one of the Department's federal Home and Community-Based Services Waivers.

6. Expansion of NF A/B Waiver (SB 643)

SB 643 (Chapter 551, Statutes of 2005) requires the Department to increase the number of NF A/B Waiver slots by 500, reserving 250 for beneficiaries transitioning from facilities, only to the extent it can demonstrate fiscal neutrality within the overall Department budget and federal fiscal neutrality as required under the terms of the federal waiver. The Department is currently evaluating whether the expansion can be implemented on a budget neutral basis.

7. Rotavirus Vaccines for Children Program

Rotavirus vaccine has been approved for inclusion in the Vaccines for Children Program. The vaccine, Rotateq, used to prevent a leading cause of severe acute gastroenteritis in children under five years of age, is administered orally beginning at 6 to 12 weeks of age and can be given concomitantly with other vaccines. The Advisory Committee on Immunization Practices recommends a dosing schedule of 2, 4 and 6 months.

8. Self-Directed HCBS Waiver—CDDS

Subject to approval by CMS of a 1915(c) waiver, beginning in FY 2007-08 the Department will implement a Self-Directed Services (SDS) model of funding and service delivery that will cap individual budgets in exchange for increased consumer control over services. The Budget Act of 2005 contains trailer bill language to implement the SDS program. Since then, the Administration has continued to refine its proposal based on input from legislative staff and stakeholders. Implementation of SDS has been linked to the roll-out of the California Developmental Disabilities Information System (CADDIS) in the regional centers. The status of the CADDIS project is currently under review by the Administration. Should CADDIS be approved, implementation will be phased in at the regional centers consistent with the CADDIS implementation timeline. The Department is assessing options for implementing SDS in the event CADDIS is not available.

INFORMATION ONLY:

FAMILY PACT

1. Family PACT DME and Laboratory Contracting

   The Health Trailer Bill of 2002 provided the Department with the authority to enter into exclusive or nonexclusive contracts on a bid or negotiated basis with manufacturers, distributors, dispensers or suppliers of appliances, durable medical equipment, medical supplies, and other product-type health care services, and with laboratories for clinical laboratory services, for the purpose of obtaining the most favorable prices to the state and to assure adequate quality of the product or service.

2. Family PACT Intrauterine Contraception Devices Rate Increases

   The current reimbursement rate for intrauterine contraception (IUC) devices is below the wholesale cost. IUC devices are the longest lasting non-permanent birth control method available. These rates will be increased for the two available IUC devices to meet provider costs. It is assumed the costs for the rate increase will be offset by the savings due to the switch from other more costly birth control methods.

BREAST AND CERVICAL CANCER TREATMENT

1. Annual Redeterminations for BCCTP

   The Department will process annual redeterminations for women in the BCCTP. A woman found no longer eligible for federal BCCTP could either be eligible for another Medi-Cal program through the county, eligible for the State-funded BCCTP for cancer treatment services, or not eligible for any further assistance. If a woman is no longer in need of treatment, has become 65 years of age, or has obtained creditable health coverage, the case will be referred to the county for a determination of whether the woman meets the eligibility requirements for any other Medi-Cal program. The county will issue a Notice of Action granting or denying Medi-Cal coverage. If the county determines that the woman is not eligible for another Medi-Cal program, or is eligible with a share of cost, eligibility will be determined under the State-funded BCCTP. Women without Medi-Cal linkage (parent of children with income under 100 percent of poverty, aged, blind or disabled) will not obtain Medi-Cal coverage with the counties. If they are still in the need for treatment, they will be considered for State-funded BCCTP eligibility, with services limited to breast and/or cervical cancer treatment for the 18 to 24 months of coverage**.**

   BCCTP does not have experience yet to be able to quantify the local assistance impact of the redeterminations. There are many possible outcomes of the redeterminations, and the extent to which BCCTP is able to do the redeterminations will depend on receiving the additional staff requested.

INFORMATION ONLY:

REDESIGN

1. Managed Care Expansion
   The Budget Act of 2005 included geographic expansion of managed care in 13 additional counties. This action included approval to mandatorily enroll seniors and persons with disabilities (SPDs) in any of the expansion counties with County Organized Health Systems. The Department continues to work with the expansion counties.

   Health Care Options costs associated with the expansion will begin in FY 2007-08.

MEDICARE MODERNIZATION ACT OF 2003

1. MMA Low-Income Subsidy Eligibility Determination

   Medicare Part D requires cost sharing in the form of premiums, deductibles, and coinsurance. Low-income subsidies (LIS) will provide assistance for these cost-sharing expenses for certain low-income/low-resource individuals. All full-scope Medi-Cal individuals and certain others who receive Medi-Cal for their current Medicare Part A and Part B cost sharing will automatically qualify for these subsidies.

   Individuals who are not on Medi-Cal will have to apply for LIS. Applications will be available from the SSA as well as from various consumer-oriented community service groups and CWD. If these applications are completed and returned to the counties, the SSA has offered to process them and determine eligibility for the low-income subsidies. Counties will only need to forward the application to SSA. However, should an individual insist that the state make this eligibility determination and not forward the application to SSA, the MMA requires that the state have a process to make this determination. In California, this determination will be handled at the State level. No county systems changes will be made to determine LIS eligibility or to transmit LIS eligibility to MEDS. The number of individuals who will insist that the State complete their low-income subsidy determination is expected to be very small.

MANAGED CARE

1. Capitated Rate Methodology Project

   An alternative to the current methodology was developed for capitated rates for Managed Care Plans due to new federal regulations. These regulations required that as of August 13, 2003, all capitated rates for Managed Care Plans, which include County Organized Health Systems, Two-Plan Model, and Geographic Managed Care, must be certified by an actuary as actuarially sound. Rates will now be calculated based on data from managed care plans. However, California law provides that rates may not exceed the fee-for-service equivalent. The Department is continuing to improve and refine the methodology and is pursuing incorporation of encounter data from all plans. The technical nature of this work requires expert knowledge and experience in the area of government and commercial health care. The Department has signed a contract with Mercer Government Human Resource Consulting to obtain an independent and unbiased review and assistance in the development, implementation and monitoring of new rate methodology(s) and incorporation of encounter data.

INFORMATION ONLY:

2. Demonstration Waiver for Persons Infected with HIV Who Are Not Disabled

   AB 2197 (Chapter 684, Statutes of 2002) directs DHS to submit a demonstration waiver to CMS to expand Medi-Cal eligibility to HIV-positive persons who are not disabled, but who would otherwise qualify for Medi-Cal. It also requires DHS to conduct outreach and awareness activities to encourage increased voluntary enrollment into managed care plans of individuals who are eligible already for Medi-Cal due to an AIDS-related disability. The savings generated from increased managed care enrollment would be used to offset the costs of expanding Medi-Cal eligibility to the HIV-positive population. Beginning January 2003, DHS began compiling information on savings generated from voluntary managed care enrollment of AIDS-related disability beneficiaries. The Department has submitted a concept paper to CMS outlining how the program would operate and how the savings would be calculated. At this time there is no projected implementation date for this proposal. The Department is currently tracking the trend in growth of AIDS beneficiaries in managed care programs. To date, enrollment has not grown sufficiently to warrant implementation of the program.

3. Managed Care Rate Increase Reimbursement

   The University of California is exploring transferring funds to the Department for the purpose of providing capitation rate increases to CalOPTIMA, a County Organized Health System (COHS) contractor operating in Orange County. These funds would be used for the nonfederal share of capitation rate increases that would be paid to CalOPTIMA.

   The County of Los Angeles and LACare, the Local Initiative operating under the Two Plan model in Los Angeles County, have conceptually agreed to request that the Department take steps to pursue a transfer of funds to the Department to be used for the nonfederal share of capitation rate increases that would be paid to LACare.

OTHER: AUDITS AND LAWSUITS

1. *Clark vs. Belshé* – Ongoing Rate Increase

   The Court ordered the Medi-Cal program to increase fees paid to dentists from 55 percent (Phase I) to 80 percent of billed effective November 1, 1992, based on June 1992 cost data. On September 30, 1996, the Court dissolved all aspects of the injunction except for an access plan for sixteen underserved counties. In September of 1998, the final report regarding access for those counties was submitted. The Department decided against requesting that the judge lift his injunction. Accordingly, the injunction remains in effect. The judge has taken the report and a motion to dissolve the case under submission, and indicated he would provide a written ruling. To date, no final decision has been made by the judge. In November 2003, DOF reduced funding by 50 percent in fiscal year 2002-03 and eliminated all funding thereafter, for the change order to the dental fiscal intermediary contract for implementing an outreach program in the underserved counties.

INFORMATION ONLY:

2. *Sanchez, et al. vs. Johnson, et al.*

The defendants in this case, the Secretary of the California Health and Human Services Agency, and the Directors of the California Departments of Developmental Services, Health Services, and Finance, were sued in their official capacities. Plaintiffs allege that the State's reimbursement for community based services for the developmentally disabled has resulted in persons with developmental disabilities being unnecessarily segregated in institutions, in violation of the federal Americans with Disabilities Act (ADA) and Rehabilitation Act. They also maintain that the State's Medi-Cal reimbursement to community-based providers is too low in violation of the "access" and "efficiency, economy, and quality of care" requirements of Medicaid law at 42 United States Code section 1396a(a)(30)(A). On January 6, 2004, the federal district court ruled that the plaintiffs had no right of action to challenge Medi-Cal reimbursement rates under section 1396a(a)(30)(A) and that the State reimbursement did not violate the ADA and Rehabilitation Act. The plaintiffs filed a notice of appeal. On December 8, 2004, a hearing was held before the United States Court of Appeal. On August 2, 2005, the Court of Appeals for the Ninth Circuit affirmed the district court judgment, holding that: 1) neither Medi-Cal providers nor beneficiaries had a right to challenge Medi-Cal rates under section 1396a(a)(30)(A); and 2) the State's reimbursement did not result in a violation of either the ADA or the Rehabilitation Act. On August 23, 2005, the plaintiffs filed a petition for rehearing en banc with the Court of Appeals. **On November 30, 2005, the Court of Appeals denied the petition for rehearing en banc.**

3. *Cedars-Sinai Medical Center vs. Diana Bontá*

The Cedars-Sinai Medical Center lawsuit alleges the medical center was entitled to receive cost-based reimbursement from Medi-Cal for (1) retro-qualified patient services, and (2) CCS patient services after entering into the UCLA/CSMC Delegation Agreement and Delegation Amendment. The Department determined that retro-qualified patient services and CCS patient services were covered under the 1992 UCLA/CSMC Delegation Amendment which specified that Cedars-Sinai be paid the contract rate per day. Therefore, the Department recouped the difference between the cost-based reimbursement amounts received by Cedars-Sinai for these two types of services and the contract rate per day stated in the UCLA/CSMC Delegation Amendment.

In January 2000, Cedars-Sinai Medical Center filed a petition for writ of mandate in Los Angeles Superior Court seeking reversal of an administrative hearing decision that had affirmed the recoupment of $35,647,647 for payment of services during fiscal years 1993-94 through 1997-98. The Los Angeles Superior Court ruled in favor of the Department of Health Services with the exception that the Department reduce the amount of the recoupment by ten percent and return $3,564,764 to the hospital. Cedars-Sinai has appealed this ruling. ~~Thus, any payment most likely will not be made until FY 2004-05.~~ If Cedars-Sinai prevails at the appellate court level, the Department may have to return the entire recoupment amount plus post-judgment interest. **If so, any payments would not have to be returned before FY 2006-07.**

INFORMATION ONLY:

4. *Rodde, et al v. Bontá, County of Los Angeles, et al.*

This lawsuit was filed on March 6, 2003, on behalf of a class of plaintiffs made up of disabled Medi-Cal beneficiaries in Los Angeles County who currently need or may need in the future the sort of services provided at Rancho Los Amigos National Rehabilitation Center (Rancho), which is owned and operated by the County of Los Angeles. The lawsuit was prompted by the County's plan to close Rancho. The plaintiffs filed the lawsuit in an effort to force the County to keep Rancho open. Absent Rancho staying open, the plaintiffs contend that the Medi-Cal program will be in violation of various federal Medicaid laws, including but not limited to 42 United States Code section 1396a(a)(30)(A) which requires rates for covered services to be sufficient to assure adequate access. Plaintiffs also contend that closing Rancho will cause both the County and the State to be in violation of the Americans with Disabilities Act. If Rancho closes, plaintiffs have indicated that they will be seeking a court order to require the State to increase Medi-Cal rates to the extent necessary to assure adequate access. On February 5, 2004, the Ninth Circuit Court of Appeals affirmed the lower court's preliminary injunction against Rancho's closure. ~~To date, no~~ **No** order has **been** issued against the State. ~~The trial is scheduled to begin on February 6, 2006.~~ **In September 2005, the plaintiffs and Los Angeles County entered into a settlement to keep Rancho open for at least three more years. The State is being dismissed as a defendant in the lawsuit.**

5. *California Association of Health Facilities (CAHF) v. Department of Health Services*

This lawsuit was filed in state court on January 17, 2003. The Department subsequently removed the case to federal court. The plaintiff challenges the validity of Medi-Cal rates paid for long term care (LTC) services during the 2001-02 rate year (August 1, 2001, through July 31, 2002). Plaintiff contends the rates paid during the 2001-02 rate year violate federal Medicaid laws, including 42 United States Code section 1396a(a)(30)(A), and also contends the Department has not complied with the California Administrative Procedure Act (APA) with respect to the adoption of regulations to implement rates. Plaintiff seeks a court order requiring the Department to establish higher LTC rates for the 2001-02 rate year and make retroactive payments to LTC facilities at those higher rates. On July 15, 2003, the Federal District Court for the Northern District of California ruled that the plaintiff had no judicially enforceable right to challenge the rates based on federal law. In August 2003, the federal court remanded the case back to state court for litigation on the plaintiff's contentions that the Department failed to comply with state law in establishing the 2001-02 rates.

The plaintiff has filed a second amended complaint in the now pending state court action. The plaintiff contends that the Medi-Cal rates paid in 2001-02 were established in violation of the federally approved state plan and a state regulation that requires the program to be administered in accordance with the state plan. The plaintiff has filed a lawsuit raising similar issues for the 2002-03 rate year (August 1, 2002 through July 31, 2003). In both lawsuits, the plaintiff seeks a court order that would require the Department to recalculate higher rates for the 2002-03 rate year and pay the long term care facilities the additional amount owed at the higher rates. On June 15, 2004, the court entered judgment for the Department in both cases. The plaintiff filed an appeal with the State Court of Appeal. The parties ~~are currently in~~ **have completed** the process of preparing and filing appellate briefs. **The Court of Appeals has not yet set a hearing date.**

INFORMATION ONLY:

6. *California Association of Medical Product Suppliers, et al., v. Sandra Shewry*

   On June 10, 2004, the plaintiffs filed a complaint in the United States District Court seeking injunctive and declaratory relief from reductions in the Medi-Cal fee-for-service reimbursement rates for durable medical equipment pursuant to recently enacted W&I Code section 14105.48. ~~A trial is currently scheduled to begin on May 8, 2006.~~ **On January 18, 2006, the plaintiffs filed a dismissal of their federal court lawsuit, "without prejudice."**

7. *California Association for Health Services At Home, et al., v. Sandra Shewry*

   This lawsuit was filed on April 27, 2004 for reimbursement, injunctive, and declaratory relief premised upon the Department's alleged violation of the Medicaid Act's "reasonable promptness" requirement, the Medicaid Act's "access" requirement (including efficiency, economy, and quality of care, federal regulation (42 C.F.R. § 447.204)), and the State Plan. The suit alleges the Department has failed (at least since 2000) to conduct an annual review/studies for home health care services and to adjust the rates accordingly. ~~The case is currently pending.~~ **The Court held that providers failed to demonstrate they are entitled to an award of retrospective monetary relief designed to compensate them for the difference between the rates actually paid and the rates that the providers contended should have been paid. However, the Court did hold that the State Plan requires the Department to conduct a rate review this year and annually thereafter. The providers appealed the judgment and the Department cross-appealed. The briefing is underway.**

OTHER: REIMBURSEMENTS

1. New CMS State Plan Amendment Requirements

   CMS issued a letter effective January 1, 2001, stating that if the State does not respond to requests for information on SPAs within 90 days, CMS will initiate disapproval action on the amendment. Also, for plan amendments submitted January 1, 2001, and thereafter, CMS will not provide FFP for any SPA until it is approved.

2. Federal Upper Payment Limit

   The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of facility to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Spending could not exceed the UPL for each of the three hospital categories. Furthermore, spending under the entire waiver was also capped by CMS, but on a calendar year basis.

   Based on the terms and conditions of the Medi-Cal Hospital/Uninsured Care Demonstration, the UPL will only apply to private hospitals and non-designated public hospitals that are part of the category of "non-state government-owned hospitals". The UPL for designated public hospitals will be audited costs.

INFORMATION ONLY:

3. Selective Provider Contracting Program Waiver Renewal

The Selective Provider Contracting Program (SPCP) waiver that allows California to negotiate contracts with hospitals for inpatient services on a competitive basis expired on August 31, 2005. The Department replaced the current SPCP waiver with a Section 1115 waiver. This new waiver, the Medi-Cal Hospital/Uninsured Care Demonstration Waiver has been approved by CMS effective September 1, 2005. SB 1100 is the legislative framework for implementation of the MH/UCD.

4. Delay Checkwrite from June to July

Beginning with FY 2004-05, the last checkwrite of the year will be delayed until the start of the next fiscal year. During June of each fiscal year, one checkwrite for all Medi-Cal program providers whose claims are processed by the fiscal intermediary will be delayed and paid during the next fiscal year. This delay resulted in a decrease in expenditures in FY 2004-05 only.

5. L.A. Waiver Reimbursement for Public Private Partnerships

The L.A. Waiver allowed Public Private Partnership (PPP) community clinics to be paid on a cost-based reimbursement basis. The L.A. Waiver ended June 30, 2005. Nine PPPs did not obtain Federally Qualified Health Center (FQHC) status, which allows reimbursement by indexed growth rates applied to a base year cost. These nine community clinics have reverted back to Medi-Cal's FFS reimbursement rates. The FFS impact of this change on the Medi-Cal budget is expected to be very small. However, there may be savings in the cost-based settlements. Currently, the Department is working on 2003 settlements. Savings from no longer having cost-base reimbursement settlements will not be seen until 2008 or 2009.

6. Intrauterine Contraception Devices Rate Increases

The current reimbursement rate for intrauterine contraception (IUC) devices is below the wholesale cost. IUC devices are the longest lasting non-permanent birth control method available. These rates will be increased for the two available IUC devices to meet provider costs. It is assumed the costs for the rate increase will be offset by the savings due to the switch from other more costly birth control methods.

7. ICF/DD-H and ICF/DD-N Rate Bundling

The Department is in the development stages of incorporating adult day treatment and the associated non-medical transportation into the Intermediate Care Facilities for the Developmentally Disabled Habilitative (ICF/DD-H) and Nursing (ICF/DD-N) rates to obtain FFP. The Department is working on a State Plan Amendment and reimbursement concepts and will seek CMS approval for implementation in FY 2006-07. Currently, adult day treatment and the associated non-medical transportation are provided by CDDS with 100% State General Fund.

8. Specialty Mental Health Waiver Overpayment

In November 2005, CDMH notified the Department of overpayments for beneficiary and EPSDT mental health services provided through the Specialty Mental Health Waiver during FY 2003-04 and 2004-05. CDMH is in the process of identifying the total amount overpaid. When the amount is identified, the Department will notify CMS and include a plan for repayment of FFP.

INFORMATION ONLY:

OTHER: RECOVERIES

1. Retroactive Medicare Premium Payment for SSI/SSP Administrative Error Cases

   The Social Security Administration has determined that approximately 20,000 SSI/SSP recipients may have been qualified to receive Medicare benefits and will establish an application process for them to apply for Medicare benefits. CMS is requiring states that have 1634 agreements to pay retroactive premiums for these recipients that are found eligible in those instances where the states also have a buy-in agreement. California currently has a buy-in agreement for Medicare Part B premiums. California may be able to obtain Medicare reimbursement for services provided to these beneficiaries.

FISCAL INTERMEDIARY: EDS

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

1. HIPAA National Provider ID Health Care Options Assessment

   The HIPAA Administrative Simplification provisions require the U.S. Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. They also address the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of standardized electronic data interchange in health care.

   The current HCO system must be assessed to determine the changes that will be necessary to accommodate the National Provider ID. This assessment will consist of a gap analysis to define the difference between current system operations and post-provider ID operations. Following the gap analysis, remediation will be undertaken to bring the system into full operational compliance with the National Provider ID. This assessment is expected to take place in FY 2007-08.

2. Takeover of New Health Care Options Contract

   Takeover, which begins five months prior to the beginning of the new contract (FY 2007-08) will overlap the current contract.

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Fully Incorporated Into Base Data/Ongoing

ELIGIBILITY

BENEFITS

1. ADHC Moratorium

   The Budget Act and Health Trailer Bill of 2004 implemented a twelve-month moratorium on the certification of new adult day health care centers beginning August 16, 2004, including in-house applications, with specified exceptions. The Budget Act and Health Trailer Bill of 2005 included language to allow specific additional exemptions to the moratorium. This moratorium will be extended until the waiver or SPA is ready for implementation. The pending SPA or waiver will include a rate redesign that is anticipated to achieve program savings.

FAMILY PACT

BREAST AND CERVICAL CANCER

REDESIGN

MEDICARE MODERNIZATION ACT OF 2003

MANAGED CARE

1. Office of State Long-Term Care Ombudsman

   Federal funding has been requested for the Office of the State Long-Term Care Ombudsman. This office trains and coordinates local staff and volunteers to investigate complaints made by or on behalf of residents. CMS denied the FFP; however, an appeal of the decision is currently under review.

OTHER: AUDITS AND LAWSUITS

DISCONTINUED ASSUMPTIONS

Fully Incorporated Into Base Data/Ongoing

OTHER: REIMBURSEMENTS

1. Drug Budget Reduction

The Health Trailer Bill of 2002 includes the following Medi-Cal drug budget reductions:

A. AIDS and Cancer Drug Supplemental Rebates

Requires manufacturers of AIDS and cancer drugs to enter into contracts with the State to provide additional supplemental rebates.

D. Enteral Nutrition Rate Reductions

Reduces the rates of reimbursement for enteral nutrition products.

E. Nonsteroidal Anti-inflammatory Drugs

DHS contracts with drug manufacturers to obtain additional state supplemental rebates.

F. Increased Utilization Controls

Adds staff to review drug utilization patterns, establish duration of therapy utilization controls, and establish frequency of billing utilization controls. These controls will reduce inappropriate drug use.

G. Preferred Prior Authorized Drugs

Creates within the Medi-Cal List of Contract Drugs (List) a section of "preferred but prior authorization still required" (PPA) drugs. The preferred status of the drugs in this section would be based on contracting with Medi-Cal for rebates or a preferred outcome from a departmental analysis. Listing in the Preferred Section would mean that the prior authorization review would authorize only the preferred drug, unless the prescribing physician justified the need for a drug not listed in the section. The existence of the PPA allows the Department to provide tiered drug benefits in some therapeutic categories.

H. Reduce Rxs to AWP

10%/No Direct Pricing — Reduces the current payment methodology for all drugs from the Average Wholesale Price (AWP) – 5% to the AWP – 10%, and eliminates direct pricing of drugs.

J. Over-the-Counter Drugs

Changes the current professional fee (dispensing fee) for over-the-counter drugs from a 50% mark-up on cost to a flat dispensing fee equal to that used for prescription drugs.

The drug budget reductions required changes to the FI-operated drug reimbursement systems and the addition of a pharmacist position to the FI. Several of the changes have been implemented.

DISCONTINUED ASSUMPTIONS

Fully Incorporated Into Base Data/Ongoing

2. Medical Supply Reductions

The Health Trailer Bill of 2002 (AB 442, Chapter 1161, Statutes of 2002) includes the following medical supply reimbursement revisions:

B. Diabetic Supplies

Reduces the rate methodology for diabetic supplies from Medi-Cal's rate on file + 25% mark-up to Medi-Cal's rate on file + dispensing fee equal to that for prescription drugs.

C. Incontinence Creams and Washes

Establishes new quantity limitations on incontinence creams and washes to help reduce inappropriate utilization.

D. Incontinence Supplies Reimbursement Reduction

Reduces reimbursement for incontinence supplies by 2%, from 40% to 38%, i.e., the lesser of the provider's usual and customary rate or Medi-Cal's rate on file + 38% mark-up.

E. New Medical Supplies

Changes the rate methodology for all new medical supplies from Medi-Cal's rate on file + 25% mark-up to Medi-Cal's rate on file + 23% mark-up.

F. Removal of Medical Supplies from Regulations

Removes the list of medical supplies and the implementation of utilization controls for medical supplies from regulations.

3. Billing Audits for Medicare Payments

The Budget Act of 2003 included an augmentation of the Department's Audits and Investigations Division of twelve permanent full-time positions to perform additional audit procedures of nursing facilities in order to identify, calculate, and recover the overpayments being made as a result of inappropriate billings and payments relating to Medicare and Medi-Cal crossover beneficiaries.

4. Speech Generating Devices

The Health Trailer Bill of 2005 amended W&I Code Section 14105.48 to allow reimbursement for SGDs and related accessories at no greater than 100% of the published Medicare rate from 80% of the 2004 Medicare rate.

DISCONTINUED ASSUMPTIONS

Fully Incorporated Into Base Data/Ongoing

OTHER: RECOVERIES

1. Beneficiary Confirmations

   As a fraud control process, the Department instituted two methods of verifying that beneficiaries actually received the benefits that providers billed to Medi-Cal. The first method is to contact a random sample of Medi-Cal beneficiaries by phone or by mail. The second method is to contact a beneficiary, in person or by mail, when a review indicates the provider's billing patterns and the diagnosis for the beneficiary do not appear to match.

2. Provider Feedback Program

   In order to ensure that providers understand the amount that they have been paid by Medi-Cal, mid-year paid claims data are sent to them at their home address. Utilization and billing profiles have been developed and providers will be notified if their profiles are significantly different than those of their peers.

FISCAL INTERMEDIARY: EDS

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Applicable

ELIGIBILITY

BENEFITS

FAMILY PACT

BREAST AND CERVICAL CANCER

REDESIGN

MEDICARE MODERNIZATION ACT OF 2003

MANAGED CARE

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

1. Teaching Hospitals

   Hospitals contracting under the Selective Provider Contracting Program (SPCP) that meet the definition of university teaching hospitals or major (non-university) teaching hospitals were eligible to negotiate for Medi-Cal Medical Education Supplemental Payment Funding, also known as the Graduate Medical Education (GME) program. Funding provided to hospitals under this program will be replaced by new funding under the MH/UCD. Please refer to Assumption MH 0.6 for a description of the new funding methodology.

2. Small and Rural Hospital Fund 688

   AB 761 (Chapter 226, Statutes of 1999) created the Small and Rural Hospital Supplemental Payment Fund (Fund 688). Under this legislation intergovernmental transfers were made into the fund that qualified for FFP to reimburse hospitals for the provision of necessary acute inpatient hospital services to Medi-Cal beneficiaries. Funding provided to hospitals under this program will be replaced by new funding under the MH/UCD. Please refer to Assumption MH 0.6 for a description of the new funding methodology.

OTHER: RECOVERIES

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Applicable

FISCAL INTERMEDIARY: EDS

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DELTA DENTAL

DISCONTINUED ASSUMPTIONS

Withdrawn

ELIGIBILITY

BENEFITS

FAMILY PACT

BREAST AND CERVICAL CANCER

REDESIGN

MEDICARE MODERNIZATION ACT OF 2003

1. MMA – FI, CA-MMIS Modifications

   Due to the MMA, the California Medicaid Management Information System (CA-MMIS) will need to be modified to ensure that Medi-Cal does not pay for the Medicare covered drugs (no FFP available) as well as to allow for the payment of claims for drugs excluded by Medicare (FFP available) if Medi-Cal permits payment. CA-MMIS will also have to be modified to accept the new Medicare drug eligibility information from the Medi-Cal Eligibility Data System (MEDS) via the Fiscal Intermediary Access to Medi-Cal Eligibility (FAME) file and modifications to the automated eligibility messages will be needed to properly inform providers of a Medi-Cal beneficiary's Medicare drug coverage, including plan name. This project will commence in the current year and extend into the budget year.

MANAGED CARE

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

DISCONTINUED ASSUMPTIONS

Withdrawn

FISCAL INTERMEDIARY: EDS

1. ACMS Redesign

   The Automated Collection Management System (ACMS) is a legacy system used by the Third Party Liability (TPL) Branch to recover Medi-Cal monies from providers, beneficiaries, estates of certain deceased beneficiaries, and liable third parties. TPL is replacing the existing system with one that is based on open architecture and commonly used industry standards. The business case justification (BCJ) has been completed, and will be forwarded to DOF in April 2006. It is estimated that the advanced planning document (APD) will be completed and sent to CMS by May 2006. Upon approval of the APD by the CMS, EDS will begin working on the project in July 2006 with an expected completion date of December 31, 2008.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DELTA DENTAL